Children's Behavioral Health Oversight Committee
June 16, 2010

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The Children's Behavioral Health Oversight Committee met at 9:00 a.m. on Wednesday, June 16, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Senators present: Kathy Campbell, Chairperson; Bill Avery; Colby Coash; Annette Dubas; Jeremy Nordquist. Senators absent: Tom Hansen, Amanda McGill, Pete Pirsch.

SENATOR CAMPBELL: (Recorder malfunction)...in Lincoln, and I'm going to have my colleagues introduce themselves. We'll start to my far right.

SENATOR NORDQUIST: Jeremy Nordquist, senator from District 7, which is downtown and south Omaha.

SENATOR COASH: Colby Coash, District 27 right here in Lincoln.

SENATOR DUBAS: Annette Dubas, District 34, Fullerton, Central City, Aurora, Grand Island.

SENATOR CAMPBELL: And we know for sure that Senator Hansen, Senator McGill, and Senator Pirsch are not going to be with us. Senator McGill is actually on a study program in Germany with a group of young legislators. There's Senator Avery. Senator Avery, I always forget what district.

SENATOR AVERY: I do too. (Laughter)

SENATOR CAMPBELL: I bet not.

SENATOR AVERY: 28.

SENATOR CAMPBELL: That's funny.

SENATOR DUBAS: Well, you're in it, so...

SENATOR CAMPBELL: Yeah, we are in Senator...

SENATOR DUBAS: ...we are in Senator Avery's district, yes.

SENATOR AVERY: Yes.

SENATOR CAMPBELL: We have to say that. So we want to welcome all of you to our continuing series of meetings on the LB603 oversight committee. Today we're going to have somewhat of an emphasis, at least in the morning, not somewhat but major, on the access issues for how young people may be using the services in residential care. And I do really want to thank Topher Hansen--and, unfortunately, Mr. McCarville can't be with us this morning--want to thank those two gentlemen who came to see me months ago and said that they had decided that they would begin doing some tracking and obviously they then went ahead and hired Dr. Schmeeckle to help their report along. So we are delighted to have them and I appreciate the effort that the agencies and certainly Dr. Schmeeckle put together. One small item before we start in: We will be taking a break for lunch today and the second thing is, for the senators, the cookies here are courtesy of Kathleen Dolezal who is with us from the Policy Research. She is always kind enough to keep the Health and Human Services Committee fortified with cookies, so thank you for the tradition continuing. So with that, Dr. Schmeeckle will start off and I think that most of the senators or all of the senators received the report that you handed out and you also have a summary. So welcome and thank you.

JOYCE SCHMEECKLE: (Exhibit 1) Great. Thank you. Yes, thank you. Thank you for letting me present to you. What you have in front of you is just a summary of the full report that was presented to the Nebraska Behavioral Coalition. My firm conducts

independent research evaluation for nonprofits and foundations, and focusing on program evaluation. I've done a fair amount of work in behavioral health. So I was contracted in February this year by the Nebraska Behavioral Health Coalition to review primarily the trend in admission data we conducted from youth treatment providers to determine if their experience of a reduction in youth in residential treatment would be substantiated by data collectively from all the providers in the state. It was a...it's a limited study. It was the beginning of trying to see if we could pull data together from all the providers to just get a brief look. So it doesn't answer all of the questions that there may be out there but it's certainly a beginning. So admission data, average length of stay, reauthorization denials, and letters of agreement were collected from what we believe were a majority of the youth treatment providers in this state that provide residential treatment. The providers that provided data were Alegent, Boys and Girls Home, Boys Town, CEDARS, CenterPointe, Epworth Village, St. Monica's, Uta Halee and Cooper Village, and Youth Care, Inc.; all contributed data to this study. Youth includes children ages 0 to 18, with approximately two-thirds of the youth in the study ages 13 to 18. The Magellan reauthorization data was...as reported here, was from a report presented to the committee task force in December of 2009, so that's where that data was...came from. So as we looked at admission data that was collected from the last several years, again, the primary interest in the admission data was to analyze the trends in residential treatment admission as compared to outpatient treatment admissions. We...while there were other levels of care, obviously, provided by the providers, we didn't...they're smaller numbers and didn't necessarily see any, you know, specific trends. So as you look on figure one or review the aggregate admission data by quarter going back to January to March 2009 indicated a general trend in a decrease in residential treatment and again...and a general trend in increase in outpatient treatment admissions. And again, there's...and I'll talk a little bit about some of the limitations of the study. We didn't compare admissions data to capacity levels. As a researcher, you always...there's always that one thing, you think, crap, why didn't I (laugh)...why didn't I get that information? So, you know, there were some things that you can imagine. Admissions is not only controlled by what is authorized by Magellan, it's also dependent

upon what's available for beds in the facility, so. But this was also sort of, as we looked at authorization rates for Magellan, this...the admission data was somewhat confirmed when reviewing this information. This is authorization and reauthorization rates, so it includes both of those. There was a decrease of about 5 percent in residential treatment rates, from 94 percent to 89 percent in the first five months of this...the current fiscal year as compared to fiscal year '08-09. And while outpatient...a decline in the outpatient reauthorization, authorization rates declined only slightly. Would you like questions?

SENATOR CAMPBELL: Anybody have questions?

JOYCE SCHMEECKLE: Yeah.

SENATOR CAMPBELL: It would probably be easier if we did...

JOYCE SCHMEECKLE: Okay.

SENATOR CAMPBELL: ...as we go along...

JOYCE SCHMEECKLE: Sure.

SENATOR CAMPBELL: ...because we're pretty informal here.

SENATOR NORDQUIST: Great. Thank you...

SENATOR CAMPBELL: Senator Nordquist.

SENATOR NORDQUIST: ...for joining us today.

JOYCE SCHMEECKLE: Uh-huh.

SENATOR NORDQUIST: I guess we had a brief...a fair amount of briefing from Magellan toward the end of the legislative session and I guess the dates that they gave us, they had July 1 to February 28 of 2010. Yours goes through November. And they had residential treatment, first level approvals back at 93 percent. So looking at just the two periods that you gave shows a pretty significant decline, but have you...did you ever...not putting it on paper but did you look at a longer period of time and to see how it kinds of ebbs and flows or...?

JOYCE SCHMEECKLE: Well, we weren't very successful in our communications with Magellan...

SENATOR NORDQUIST: Okay.

JOYCE SCHMEECKLE: ...in obtaining any additional information, so I had to utilize the report that I had...

SENATOR NORDQUIST: Okay. Okay.

JOYCE SCHMEECKLE: ...and now knowing that there was another report available.

SENATOR NORDQUIST: Sure. Okay.

JOYCE SCHMEECKLE: And I...so it's subject to whatever information they...

SENATOR NORDQUIST: Sure. No, I understand. Sure. Sure.

JOYCE SCHMEECKLE: ...provided to you at the time in November...

SENATOR NORDQUIST: I understand. Sure.

JOYCE SCHMEECKLE: ...or December actually, so...

SENATOR NORDQUIST: Okay.

JOYCE SCHMEECKLE: ...I apologize.

SENATOR NORDQUIST: No.

JOYCE SCHMEECKLE: I know, but you bring up a good question, because going back further in admission data, it's very erratic,...

SENATOR NORDQUIST: Okay.

JOYCE SCHMEECKLE: ...I mean and so this is...you have to take this as this is sort of a snapshot and a beginning of trying to understand what's happening, based on individual provider's perception of what they see every day...

SENATOR NORDQUIST: Sure. Sure.

JOYCE SCHMEECKLE: ...in terms of what's happening in terms of residential treatment, i.e., empty beds, you know. So it's a good question. I'm sorry I can't answer it.

SENATOR NORDQUIST: Okay. No, no, I understand.

SENATOR CAMPBELL: Dr. Schmeeckle, it would seem to me though that it wouldn't be that hard to go back to the participating agencies and ask them on a capacity basis...

JOYCE SCHMEECKLE: Right. Yes.

SENATOR CAMPBELL: ...just that, to pick up that number.

JOYCE SCHMEECKLE: Uh-huh. Uh-huh.

SENATOR CAMPBELL: Because just my sense in talking to some of them, it's not their capacity number that may be affecting these rates but it's actual empty beds.

JOYCE SCHMEECKLE: Right. Right. It would...I would say the capacity issue is if we go back a couple of years and if admissions are lower it would indicate...I'm making an assumption at that point that they were at capacity and therefore admissions were lower. Does that makes sense?

SENATOR CAMPBELL: Right.

JOYCE SCHMEECKLE: So when we...that's why looking too far back it's too difficult to look at the trends. Does that makes sense?

SENATOR CAMPBELL: Yes.

JOYCE SCHMEECKLE: So, yes, I think currently if you look at what I have seen and I don't report here but wait lists are definitely very, very short at this point. So that would indicate that there's definitely available capacity for residential treatment and there's just fewer admissions going into the program.

SENATOR CAMPBELL: Right. Senator Coash.

SENATOR COASH: Thank you. With the Magellan authorizations, does this reflect requested treatment? In other words, were these...you know, the providers have to request a level and then Magellan authorizes it. Does this reflect what was requested or just what was authorized, or was there anything different between what the applications

said, you know, I would like residential but the authorization as outpatient?

JOYCE SCHMEECKLE: Was lower, right.

SENATOR COASH: Yeah.

JOYCE SCHMEECKLE: I don't have that data again...

SENATOR COASH: Okay.

JOYCE SCHMEECKLE: ...but that's a really excellent question. To say when we'll get...well, there's a little bit of information in terms of denials in terms from the provider perspective, so you can see an increase in that. So it's possible that Topher can answer that question at a later date but...

SENATOR COASH: Okay. Thank you.

JOYCE SCHMEECKLE: Uh-huh.

SENATOR CAMPBELL: Other questions before we go on? Senator Avery.

SENATOR AVERY: Thank you. Did you try to understand why? I know you addressed this a little bit but do you think you found the answer?

SENATOR CAMPBELL: Well, we don't have an answer. (Laugh) At the time that they decided to...and, again, Mr. Hansen can clarify as well, but at the time that the coalition decided they wanted to try to understand what was happening on a more aggregated level, they...we had a short, like about six to eight weeks of where we were trying to pull the data together so that it would be available to the committee, and then there were limited resources as well. What...to understand the why would be a fairly massive

research project and would...

SENATOR AVERY: But isn't that what you want to know?

JOYCE SCHMEECKLE: It is what we want to know. I believe that's what the providers want to know. I guess I shouldn't speak for the providers but...

SENATOR COASH: Good researcher.

SENATOR CAMPBELL: Yeah, there's a good research here. (Laughter)

SENATOR COASH: Good professor.

JOYCE SCHMEECKLE: Yes. Yes. Yes.

SENATOR AVERY: No, the why is always what you're trying to...

JOYCE SCHMEECKLE: Right. This...

SENATOR AVERY: ...achieve in a research project.

JOYCE SCHMEECKLE: Right. Right. Unfortunately, we didn't...we didn't have the time nor were there the resources at this...at this particular point dedicated to try to find the why. I mean I'm sure that that is where they want to go and depending on how things progress, I guess.

SENATOR AVERY: But you probably have some ideas but you may not be able to establish them empirically yet. But you have some understanding of this.

JOYCE SCHMEECKLE: Right. Right. From a research perspective, I wouldn't want to...

SENATOR AVERY: Yeah.

JOYCE SCHMEECKLE: ...give any of my, you know, hypotheses at this point.

SENATOR AVERY: No, and I'm not asking you to speculate but...

JOYCE SCHMEECKLE: But, yes, but I think the providers certainly have some understanding from their individual...what they're seeing and they're experiencing in their individual agencies why this is happening and what's happening, so...

SENATOR AVERY: So we should ask them, right?

JOYCE SCHMEECKLE: (Laugh) Yes.

SENATOR CAMPBELL: Well, I think that's one of the issues for our committee definitely, is obviously what is the capacity out there but are we utilizing that capacity. And perhaps utilizing it isn't enough. Is it utilized appropriately? I mean I think we all know that some of the children and youth that come into this program need residential treatment. The question that I think the providers at least posed to me was, where are the kids? If they're not in the residential treatment, and we certainly know that we're moving toward a more community based, we understand all that, but some children and youth just cannot function yet in a community-based program. So I think that's, at least from the providers perspective, when they talked to me, was really where are the kids and are they there...are they in the right place appropriately?

JOYCE SCHMEECKLE: Right.

SENATOR CAMPBELL: And if they are, do we have the capacity? That's certainly one of the issues that was raised in all the safe haven...

JOYCE SCHMEECKLE: Right. Right.

SENATOR CAMPBELL: ...was do we have the capacity.

JOYCE SCHMEECKLE: Uh-huh.

SENATOR CAMPBELL: And at this point, my concern would be that if we have the capacity there but we're seeing a decrease, where are the kids and are they there? And as you're saying, that's probably the next stage answer.

JOYCE SCHMEECKLE: Uh-huh. []

SENATOR CAMPBELL: But that's the answers I'm looking for anyway. Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. Going back to the question Senator Avery asked, you know, the why, I mean I think that's the reason why we are here, is why did we end up where we were at with safe haven and, you know, why were those children...why was that the last straw for many of those parents.

JOYCE SCHMEECKLE: Right. []

SENATOR DUBAS: And so you talked about how much more time it would take to really do that in-depth kind of research, so could you kind of give me a, if you were able to really get to the why of it, what would it take as far as resources and time? A pretty hard question to answer. []

JOYCE SCHMEECKLE: Well, I mean, yeah, I mean to answer the question, I think, you know, in truth, to find out what the truth is, I mean you have to...you have to, you know,

understand so what are the other...and we did...we did talk about looking at numbers in shelters detention, so the other side of where kids may be held, so to speak. If they're not in treatment, is there another place where they're being sort of somewhat in the system? But then you need to also, you know, look at community based now that these (inaudible) community-based opportunities for families. So you have to take a systemwide approach and try to get a grasp again of what's happening. But I...but then you also need to talk to families. I mean so there's the data collection but then there's that qualitative piece, what's really happening to kids, what's the...what's the individual impact. Are families having more difficulty getting their youth into residential treatment and what are consequences of that? And then long term, that's what we don't know. What is a long-term consequences of having fewer youth in residential treatment? What's the long-term impact of them getting...being to the costs to society? Are they getting into criminal justice issues? Are they needing repeated treatment as adults? Are they homeless? Are they...you know, so all of those things that obviously take a long time to impact, but you can also look at current research that's being done maybe in other states as well to see if there's some impact studies. But it's a big...it's a big question and it's a big study. I mean it certainly can be done but I know, you know, there you have to define what is it you want to know. What is it that you think is...creates a successful outcome for youth that have received treatment, whether it's outpatient or residential? I know at the beginning of our discussion with the providers, you know, the question was if...if you have to say are youth and families healthier today and, therefore, are in less need of residential treatment, that's the question. You know, that's the big question, the other side of the equation. I mean is something happening within the environment of families and youth that is changing the need for the type of level of treatment that they need? And, you know, I think anecdotally or at least personal perception or experience, we would say that families are still in great need and, therefore, youth are still in great need as well. Does that help at all? []

SENATOR DUBAS: Yes, thank you. []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR AVERY: But the answer we... []

SENATOR CAMPBELL: Oh, sorry. []

SENATOR AVERY: ...want or would like to have is the earlier one and that is that the need for services is less. That's one. []

JOYCE SCHMEECKLE: The need for services is less. []

SENATOR AVERY: That's the answer we would like, but it may not be the accurate answer. []

JOYCE SCHMEECKLE: But why is the need for services less is what you want...you want to know. Is, yes, you want to...I mean I understand the cost issue and the financial resources, the issue that...the world we live in right now is that, you know, there aren't an unlimited number of dollars to provide unlimited number of services. So needing less services, yes, is...from that perspective is good but what...is that an immediate sort of look at let's cut dollars now but long term are you going to be paying more for providing additional services as adults if youth don't get help now, the right level of care of help? []

SENATOR AVERY: Well, let me explain what I meant by that... []

JOYCE SCHMEECKLE: Okay. []

SENATOR AVERY: ...kind of flippant response. That is that ultimately what we would hope to achieve is that families are doing better, and that's why authorization rates are down, because of a lower need for them. []

JOYCE SCHMEECKLE: Uh-huh. I see what you're saying. So there are other services that are being provided maybe at the family level that are reducing the... []

SENATOR AVERY: Or families are just doing better... []

JOYCE SCHMEECKLE: Getting better. Families are doing better. []

SENATOR AVERY: ...and, therefore, the need is less because of that. I mean ultimately that's what we're trying to achieve in the state... []

JOYCE SCHMEECKLE: Uh-huh. Right. []

SENATOR AVERY: ...and this committee is trying to find out what's the truth. []

JOYCE SCHMEECKLE: Right. Yeah. Right, yes. []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: I guess kind of along those lines, in your...in preparation for this report on the number of requests, have they...have you seen any significant changes in those, at least during the time period you looked at, and I guess we don't know if it's because of the families or have you heard, at least anecdotally, of kind of the change in the mind-set of the providers? Are they so discouraged that maybe they don't pursue residential treatment with some kids like they should? []

JOYCE SCHMEECKLE: But let's...that's a good question and let's look at the rest of the data... []

SENATOR NORDQUIST: Okay. []

JOYCE SCHMEECKLE: ...and I think that might help you understand a little bit. We looked at average length of stay, and again this is what is...again, what is the amount of time that a youth needs in residential treatment to become successful as they move on with their life. But just to look at, it's definitely decreased from a year ago, from 209 days, on average for the group of providers that provided data, to 149. And again, I'm not going to say whether that's good or bad. That's again another question whether that is helpful or not to the youth, so. But the Magellan reauthorization denials, so this kind of gets to the number of requests, so you can see we had two providers that didn't have baseline data so this is without their data, so that went from 1, in the first...the last two quarters of '08-09 fiscal year, to 23, which is a longer time period. It's about...it's eight months but if we...if you see on my notation, if we add in the other two providers that didn't have previous baseline data, there were 66 reauthorization denials and 7 state appeals during that time frame, which most of the...a few of the providers are experiencing a lot of this, denials, that they're having then to go to appeal or to get letters of...letters of agreement have also increased substantially for several providers. []

SENATOR NORDQUIST: Uh-huh. The state appeal that comes after a second review by Magellan is that, or how many does that process work? []

JOYCE SCHMEECKLE: Topher, is that...the appeal, I'm trying to... []

SENATOR NORDQUIST: Isn't there...if you're denied you can...you can appeal that. []

JOYCE SCHMEECKLE: Right, you can ask for a letter of agreement. Hopefully you ask for a letter of agreement so that they'll change their mind basically on their initial decision or you can go and get a state appeal. []

SENATOR NORDQUIST: Okay. Any idea on the number? Of the seven that were appealed to the state level, any idea how many of those were approved?

JOYCE SCHMEECKLE: I don't, I'm sorry. Right.

SENATOR NORDQUIST: Okay. []

JOYCE SCHMEECKLE: Yeah, I don't. So does that help answer what you were asking? []

SENATOR NORDQUIST: Yeah. Yeah. Yep. Yep. []

JOYCE SCHMEECKLE: Okay. []

SENATOR NORDQUIST: Absolutely. []

JOYCE SCHMEECKLE: We did attempt to get some feedback from clinicians, so psychologists and psychiatrists that are recommending...doing the assessments and recommending level of care. We didn't get a great response from them--we did an on-line survey--but from the 14 that responded, 85 percent indicated that there's...that it's more difficult to receive approval from Magellan now than it has been in the past, and 67 percent then are indicating that this difficulty has led them to recommend lower levels of treatment. That was another concern of the providers, that due to frustration from the clinicians that they'll just automatically request a lower level of care. So that's why, you know, it gets very difficult to identify what's happening. So it may look like, well, there just...the severity of children needs are less based on clinicians' recommendations, but it may be due to frustration with the system and not due to changes in youth. And then there was...they provided, in the more detailed reports, some specific indications and some specific cases where they've had to fight pretty hard to get the level of care needed that they felt for their...for the youth they were treating. []

SENATOR CAMPBELL: Dr. Schmeeckle, in your report, are those comments in the back of the report? []

JOYCE SCHMEECKLE: Uh-huh. Uh-huh. []

SENATOR CAMPBELL: On a different question, so the survey comments are from the psychiatrists or the psychologists... []

JOYCE SCHMEECKLE: Correct. []

SENATOR CAMPBELL: ...that took time to respond. []

JOYCE SCHMEECKLE: Correct. []

SENATOR CAMPBELL: Some of them or certainly one person (laugh) wrote... []

JOYCE SCHMEECKLE: Right. []

SENATOR CAMPBELL: ...rather extensive comments... []

JOYCE SCHMEECKLE: Uh-huh. []

SENATOR CAMPBELL: ...on some of them in terms of the number of psychologists or psychiatrists that had all recommended the same thing and yet it was denied. In any case, when they responded to you and gave you this anecdotal information, did they provide any data that they had been keeping themselves? []

JOYCE SCHMEECKLE: We didn't ask that. We wanted to just do a really quick survey to them just to get some initial feedback, so we didn't ask that. I mean, again, if we were to do a more extensive study this is key because this is where youth enter into the system. []

SENATOR CAMPBELL: But we've also lost some agencies that are providing residential treatment care in the state, one in Norfolk, did we not? They closed. So the other question would be, are we losing beds and capacity in addition to a change in focus? []

JOYCE SCHMEECKLE: Right. []

SENATOR CAMPBELL: In talking with the agencies that you got the numbers from, did they provide anecdotal information to you other than the data? []

JOYCE SCHMEECKLE: You know, I think they did provide some limited. []

SENATOR CAMPBELL: But it's not categorized the same as... []

JOYCE SCHMEECKLE: No. No, it was...we really...it was really a numbers gathering. I mean I think a few people responded on some specific, you know, specific incidents that had happened but nothing as in-depth as what you saw from the clinicians. So again, there's more of that. There's more trying to understand, from a case study perspective, individuals that...youth that may have had some certain challenges in the system. []

SENATOR CAMPBELL: Right. Because that would get at some of Senator Nordquist's questions and... []

JOYCE SCHMEECKLE: Uh-huh. []

SENATOR CAMPBELL: ...in terms of what is happening. Because I would guess some of the providers here provide multiple levels of care and could at least give some idea of what is happening. And one of the questions that we talked about at our last meeting, and I appreciate that Mr. Reckling is here today, was the question of whether we are beginning to see more movement between the behavioral health side and the child

welfare side because of the emphasis of wraparound to that family. Was there any indication as you visited with people on that area? []

JOYCE SCHMEECKLE: Yeah, and again the study was set up to basically send out spreadsheets and gather data and so I did not do provider interviews, again because it was...it's a very limited study. I just want you to know that it's very limited but it's the beginning of them trying to work together as a coalition to put information together. []

SENATOR CAMPBELL: And I appreciate that very much. And certainly from the beginning of the discussion from Mr. McCarville and Mr. Hansen it was very clear that we knew it would be limited to begin with, but the whole idea was to give a snapshot in time and a concern. I have to say, after I read the report certainly red flags went in my mind in concern in terms of what exactly is the picture out there. Because part of the job of this committee is going to be to recommend what services and programs do we need or what do we have that needs enhancement. And your figures would begin to tell us that we ought to zero in more specifically on what's happening in residential treatment. And if we're moving to lower levels of care, are we being successful or are those children coming back into the system? Did any of them comment whether their figures represented children who were coming back? []

JOYCE SCHMEECKLE: We didn't do readmittance as a subcategory of admissions, so we don't know the readmittance number, which is difficult. You know, it is...looking at numbers and levels of care, so they may readmit but they may readmit at a different level of care, and so trying to understand it again is...can be somewhat complicated. It's a complex issue but I think it's good that you voice your questions that you'd like answered. I think that's important if...for the providers to know what are your questions in terms of going forward and is there more research...what research would you like to be done and are your decisions going to be based on that research. []

SENATOR CAMPBELL: Well, I think it certainly raises more questions for us. We've

had some dialogue with Magellan, as Senator Nordquist indicated, and we've indicated to them that we would like them to come back on various occasions to follow up on the data they're checking. So most likely, that will be another step for us. Other questions? Will you continue, are the providers continuing the study or are we still at that question level? []

JOYCE SCHMEECKLE: We haven't had any conversations about where we're going next, so I think that's up to the providers to discuss and see what next steps are. []

SENATOR CAMPBELL: Okay. Thank you, Dr. Schmeeckle. []

JOYCE SCHMEECKLE: Uh-huh. []

SENATOR CAMPBELL: It was very informative having your report and I think it does give us a window in time... []

JOYCE SCHMEECKLE: Great. Thank you. []

SENATOR CAMPBELL: ...and raise some flags for us to look at. []

JOYCE SCHMEECKLE: Raise some flags, yes. []

SENATOR CAMPBELL: Absolutely. []

JOYCE SCHMEECKLE: Well, thank you for your good questions. []

SENATOR CAMPBELL: Thank you. We're going to continue with the program agenda that we have before us and Topher Hansen is here to represent both himself and Mr. McCarville, who was called back to his office, somewhat unexpectedly. I think he might have been halfway here. []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: Good morning and thanks for coming. []

TOPHER HANSEN: Good morning. Thank you for asking. And my name again is Topher Hansen. I'm the executive director of CenterPointe and we provide both youth and adult services, and our youth services consist of a residential treatment center and outpatient and now intensive outpatient. I can tell you, relative to our scope of services, our youth services are the smaller part and they're getting smaller all the time in that our outpatient services have never been...it's sort of been as a follow-up type service and we've never banged the drum very loudly so it hasn't been a very large program, but it is there for utilization of kids in follow-up and aftercare and those kinds of things. We started our intensive outpatient recently to help provide some greater continuum of care because our residential program is now half of what it used to be, and that has been an effort on our part. One, we've always wanted to expand our continuum but we've been afraid, to the extent that we started intensive outpatient, that that would be seen as a less costly measure and that people would be admitted there rather than in our residential program and it would undermine the residential program and it would go away. We don't think somebody who is admitted into residential could be better served in intensive outpatient but we over the years, and I've been involved in the business for 17 years, over the years we see that less costly measures, regardless of clinical necessity, are used to be a cost-saving measure. And so we try and offer the right service for the right person at the right time and don't want to get into putting people in services that really aren't going to benefit. In fact, some of the evidence is that when you put kids in lower levels of care than what they need that you actually harden a kid towards treatment. Because what they'll do is fail and when they walk out they don't say that the treatment program failed, they say I failed, and you begin to harden people, kids, towards treatment and have a more difficult time down the road. So that as kind of a background, I would also say that the Behavioral Health Coalition is who contracted

with Dr. Schmeeckle to ask the question of where are the kids and what does our system look like right now and to try and get some objective view on that. I think we're able to gain some view of it but what it said to me is we need...if we're really going to have an accurate snapshot of what this looks like we really need to have a larger study to take a look at this. This was a small picture in a small frame that we could afford and had the opportunity to do and so did because we want some objective information about what's going on. We don't feel like we're getting good information about the state of the system. I guess my conclusion, as we've experienced this process, is...comes with advice, to the extent I can offer the advice, and that is do not open these safe haven doors. We are not better. And I think people are having access problems now more than they have had before and that we have driven our system in a direction that has not necessarily been motivated by the best healthcare, the best outcome for the family. We began changing the system as a result...well, actually the system started to change prior to safe haven and the information that we received was that we have too many out-of-home placements and that Nebraska was one of the states that had the most out-of-home placements and that we needed to change that and go to a community-based system. And so safe haven then cropped up sort of in the middle of that effort. Well, my question then, as is now, is, well, why do we have too many out-of-home placements? Out-of-home placements are the symptom, not the problem. What is the problem? And I've not yet heard what the problem is. In all these months and years now that this has processed, I've not heard what the problem is. But we've proceeded down this road, we've set up a new system with the pyramid and so on and have goals around that, which are all process goals, at least the ones I've seen. Our process about how many we're going to have down here and how many we're going to get up there, that has nothing to do with the quality outcomes for the families, as you suggest, but really are more process indicators. And so the system has changed. What I heard when I sat on the committee for safe haven, so I got to listen to the parents and providers and all the folks who were talking about this, I didn't hear that we needed a 24-hour hot line, frankly. What I heard was, I can't get into services, I cannot get into services. And in the testimony provided by people it was, I have a middle-of-the-night

child, who's out of control, who I'm afraid of, who I can't find help for, who I'm trying to get into a treatment program, and I'm told that I don't have access, they're denied, or that it's going to cost me, that I have to pay for it and it's going to cost me $250 a day for an average length of stay, I'll take my facility, is four months. That's hard for anybody to afford. And so that became the barrier. There was a barrier to services at that point. So then I guess, back to my question of when we have too many out-of-home placements, so are we looking at residential treatment? Because that's really been our focus here in all the words that I've been hearing. It's really about residential care and residential care is not cheap. It's $248, is what the Medicaid rate is for that, and the...so the care is not cheap, but theoretically what we're doing is putting kids that need that level of care in the...I sure hope we're doing that, putting kids who need that level of care in that care. So then I don't know if then that's foster care or jails or treatment group homes or all the other out-of-home placements. I think we're talking about the whole aggregate of that. And so then my question is have we assessed why those folks are going to all those places and what some of the problem is? Again, I haven't heard the answer to that and so I fear we're responding to a symptom rather than a cause and that we may have some problems. Go ahead. []

SENATOR CAMPBELL: Mr. Hansen, can we go with questions sort of like we did? []

TOPHER HANSEN: Absolutely. []

SENATOR CAMPBELL: Part of the concern that I think the committee has looked at is we certainly knew that we had...from the out-of-home placements, but a lot of that had to do with the foster care system and the child welfare, you know, if we looked at that point. The worry that I have is that it wasn't that we had too many in an out-of-home placement in behavioral health issues and there is...I mean if we're moving...do you see where...I mean I think the problem was identified perhaps on the child welfare but we're moving kids out of that behavioral health portion which really maybe might not have been the target to begin with. Do you see where I'm going there? []

TOPHER HANSEN: Yes. And it also can be some of the most expensive care. Short of hospitalization, RTC is one of the most expensive levels of care and so if what we're...you know, and the numbers in residential care are not substantial. Kids don't...it's not a 15-day program. The turnover is slow because the kids that are going into those levels need...our average length of stay is four months, which I think is supported nationally as a right amount of time. There's a cost benefit and you always have to assess, as a treatment provider, when you have delivered the greatest benefit to the kid and then need to do some other thing to help transition, because after a while you're going to maybe not be benefiting them. So every treatment provider, in what they're doing, has to always assess that. Our level of care is about a four-month average length of stay and that isn't cheap, but the turnover is not substantial either. We may be, when we're operating at a dozen kids, we may see 36 kids a year total, so we're not talking about huge numbers that run through our particular program. But now, as I said, I cut that in half and, frankly, survival is the question right now because we are losing money on that program and the question is can we ramp up other services that can allow us to at least break even. I can't contribute money out of our pocket to this cause. I have a whole bunch of other programs that lose money as well and one more just isn't going to work if we're going to be able to sustain our services. So I have to be a good businessperson in conducting these services, and to the extent I continue to lose money, we will not continue services. But we're trying to hang on to that because we know that treatment works. We have a clinical psychologist who sits in...at the University of Nebraska Department of Psychology. He's on our board. He has been conducting research from our data that we've been gathering over the years. He's currently writing to publish a paper about this and what he has told me in his review of this is saying what this data is telling him is that kids that go into treatment and stay there get better and that if you don't hang on to a kid then they're probably not going to get better and if they're not in they're not going to get better; that treatment works basically. And he, as I said, is writing this and intends to publish to talk about what the historical data has shown. So we want to continue to provide this. CenterPointe also

provides a unique approach in that we integrate mental health with substance care, all in one effort, and have done that for 20 years and find...and all of our kids have diagnosed mental illness and have substance problems, and not just like a bad problem once or twice, their addiction, and that we have treated that in a way to help them get better on both fronts, and then that gives more likelihood that they will sustain recovery further down the road. But I can tell you, frankly, that the kids I see in there are kids who are extremely troubled, who have...oftentimes have very troubling family situations and it really takes an immersion to get that kid out of the environment they've been in and help immerse them in sort of a safe bubble to begin to process all the things that they're seeing. Trauma with the kids that we see is at 100 percent. A hundred percent of the kids we see have what they call adverse childhood experiences, ACE, in their history. And, you know, and we all probably have something. This is a family death, this is sexual and physical abuse, this can be divorce, things like that, that was adverse to the child. When those add up, what the clinicians tell me is you get to a tipping point of five or six where it really becomes difficult to process and to incorporate all that and have that be an experience that you an live a positive life, and kids struggle with that and adults struggle with that. So what we're trying to do is take these very troubled kids and help them process all that information, to not make it go away but to help learn how to live with all that and be healthy and move down the road. We do not want our kids to be adults in the system and that is our focus, is to try and interrupt this as early as possible so these kids get better when they leave and stay better, and that's our effort. []

SENATOR CAMPBELL: I'm going to stop you right there because... []

TOPHER HANSEN: Yeah, sorry. []

SENATOR CAMPBELL: ...we've got a couple people who have questions. Senator Nordquist and then... []

SENATOR NORDQUIST: Thank you. Well, I think that's certainly the effort of this

committee and then the policymakers in this body, that we want to go down that road. I must say I think it's an absolutely failure of state government that we have nearly 70 percent of providers that are so discouraged with the system that in their professional opinion the care that they would recommend, they're now recommending lower levels of care. And I guess from your perspective, from folks you talk to, you know, why is that? What is it? I mean why not at least make the ask? Is it time, is it, you know, for them to...for clinicians to go through the paperwork? I mean why would...why would they be at least discouraged from at least making that ask? []

TOPHER HANSEN: Uh-huh. The...I have to first say that I'm not on that end of the stick and so what I hear is from them, but it really is a time effort, that they have a million things to do. They assess a situation, make their best clinical judgment and recommendation and then it's thwarted. And rather than spend a whole bunch of time trying to defeat that decision, which they feel like they don't hold the cards, they then say, you know, cost benefit is we can get...we will just hang on to this child in an outpatient setting or do some alternative to get some care. But the frustration that I have heard from organizations that do refer is that, that it takes time, I don't have that much time to commit to every single situation. And, frankly, what I see is (laugh) they're insulted. They're saying, I am a trained clinician, and in some cases--and I think the report even cites one of those--where there are several trained clinicians, as much as a psychiatrist, psychologist, an LMHP, who have all as a team made an assessment and a recommendation, whose recommendation is overruled. That level of frustration...and we have...I have been on the receiving end of a situation like that, that there was that level of assessment. They contacted us and said, we think this person is appropriate for your program; do you? We looked at the situation; we said, yes, we would agree. And that was not allowed. And so that's the frustration with it. And so I guess in your first comment of that's what we want out of the system, policymakers do and so on, and I know that's the case from having sat here several times. And so the question I think is, how do we assess how our system is and what are our goals here in the system? And if our goal is out-of-home placement or not having that level of out-of-home placement,

then why? And again, what is the root problem there that we're trying to get to and how do we set up goals and objectives and indicators to tell us that our kids are getting better? Right now we do not know if our kids and our families are better or not. CenterPointe can tell you about its consumers. We track outcomes. We've been doing outcomes, quality outcomes, not process indicators only but quality indicators in terms of the outcome, clinical outcomes of the consumers. We have been tracking that for a long time and we do data every year and we even invite our stakeholders in to say, look, this is how we did. We think that is critical, because if you don't know how you're doing then you have to question whether you ought to be in business because you don't know if you're hurting people or helping people. So for us to move ahead and not understand some of the quality outcomes is not a good idea. And the question is now, because we're here now, the question is, how do we go about as a state assessing our system in terms of not how many out-of-placements do we have but what are the quality outcomes of the people that we're serving and are we doing better now than we did before? That ought to be our goal. And if we can do it in a cost-effective way, which we all have to do because we all have a budget to attend to, if we can do it in a cost-effective way then we need to do that. And if we can't then we have some pretty hard, tough decisions to make. You know, I have a budget like everyone else and, yet, what we have to do is help people in our program get better and then we make sure that that's what's happening so we know that we're providing an effective and efficient service. For us to get into the kind of system that we did where we privatized, basically, the system is not conceptually a bad idea and I understand that the state, operating at that level where they have a statewide system, to monitor every single contract that they have across the state is an enormous task. So, true, we need to think of ways to make that more efficient and so we can operate with some understanding of really what's going on at the ground level. I think our regional governing system is a great structure for doing that kind of balance between connections at the state level but also understanding what's happening at the ground level. Those are two important values. I fear, though, that what happened in that process is that the providers that were...that bid on those contracts then bid at one level and, subsequent to that, then the utilization

rates that they originally bid on went up, the costs; the dollars they were going to get for that went down; and the responsibilities they had in terms of the contract increased; and then the Medicaid interpretations of what medical necessity is narrowed and then forcing more people into what the lead agencies would have to be responsible for, essentially increasing their costs, and set them up for disaster. I mean it became...sort of provided a new definition of what nonprofit means by having to contribute to that. And as a result, in my estimation, as a result of that your taxes just went up because you're donors probably to organizations that do this kind of work in the community, and what the organizations are looking at now is for you to provide money to them in order to make up the difference for all those millions of dollars they're losing. And in my mind, that is the state's responsibility to step to the plate and cover the costs on those things and do it in an effective and efficient manner so we don't have to go out to the private citizenry, that is the providers don't, and say we have to have your donations or we can't make up the gap on what we're not getting for this contract. []

SENATOR CAMPBELL: I'm going to let my colleagues jump in here for just a minute. Senator Dubas has had a question here. []

SENATOR DUBAS: Well, I mean you are just outlining all of the frustrations that I've felt since getting involved with this issue and you've been in it a whole lot longer than I have, as well as many other people in the room and across the state. And I guess what I'm hearing, it appears to me, as I learn more about this, we have our horses hitched to both ends of the wagon and we're trying to get somewhere and we can't. And when I say we, I'm talking about state agencies versus the private sector. We're all trying to serve the same population. Do we have different philosophies in what we're doing? And if...it's not a question of if. I know cost drives services. Those are just the facts of the matter. So if costs do drive services, how will we make sure that those services...we're getting the appropriate services to the people based on the cost? And again, you keep saying we haven't identified the problem and I agree with you 100 percent. What is the problem? You know, the elephant is in the room. You know, now we need to name it,

now we need to figure out how to go. And I do feel that we are focusing on numbers rather than results and so it's just so big that we don't know where to start with it, you know, again... []

TOPHER HANSEN: It is big. []

SENATOR DUBAS: ...again going back to the horses and the wagons. You know, we've got the wagon, we know what we need to do, we need to get our horses on the same side so we're pulling in the same direction. []

TOPHER HANSEN: Uh-huh. []

SENATOR DUBAS: And, you know, as a policymaker and as a steward of taxpayers' dollars, I know it's not intentional but we are not spending taxpayers' dollars in a wise manner. []

TOPHER HANSEN: Uh-huh. []

SENATOR DUBAS: We're trying to address a problem but we're just...I think we're just going in circles. And so how do we start? How do we figure out where is the problem and then come at it from the same direction? []

TOPHER HANSEN: Well, I'll speak frankly. And I think what the issue is, is our orientation and it's complex because the orientation I think that you take in services is a consumer orientation; that when the consumer walks in the door, the first thing you say is how can we help you. It isn't which department do you best fit in or which funding stream do you have and then what do you need. It's how can we help you, and to orient in that fashion. And then the provider, the state, the region, whatever provider then needs to understand what access to funding streams do we have to help pay for the services of that person of these people, the family will need. And so that orientation is

the first place to start and to keep it focused on the product, which is the outcome of the consumer walking in the door. And in that orientation then I think you get better service and then you can balance that clinical and business approach to the whole issue. If what you do is start with the business end of it, which is, hi, tell me your financial status and how you're going to fit into which funding stream, then you're probably not going to be delivering the kind of care at the level that person needs because you're going to be directing it according to the system, not according to their need. And so the outcomes are going to be less good and you're more likely to do that person harm than good, which is violating the first rule of behavioral health which is at least do no harm. So the effort there, the approach, I think is that. But the complicating feature is if you're in the political system and what you have to do is go to your constituents and say we have a responsible budget, we're balanced, we've reduced Medicaid, all those things, you can't take a ten-year approach on this. Because if you're going to spend money this year and invest basically with the idea that down the road we're going to get people better and ultimately reduce the need for behavioral health services, should that happen, that's a difficult thing. That's I think complicating. That we have to spend money, spending money is not a politically expedient thing to do, but in terms of providing the necessary outcomes we have to find that balance. And again, this is not foreign to me. I do this every single day. My business requires that I provide great clinical outcomes or, you know what, I get fired, frankly, and that I balance my budget, and if I don't do that I probably don't have my job either. So I do this all the time, knowing that you have to create that tension. On the...so as to the how big is this, is there some place we can get going, it is gigantic. We are talking across the state, not just in a CenterPointe type organization, and so I think the organizational structure of that and the management of that structure, with goals and objectives at each level that talk about the kind of system outcomes that we want out of this, are important. And sort of a side note on that, about a little over a year ago the Nebraska Association of Behavioral Health Organizations and others contributed toward asking Ken Minkoff, Dr. Ken Minkoff, to provide a study of the Nebraska system in terms of whether we should move to an at-risk managed care system and what the ups and downs and so on of that might be. And he talked about

the fact that basically any at-risk system, which essentially the lead provider system is, with the exception of the state, held on to all the authority and gave all the responsibilities away, but with that exception said these are only as good as the contract written, and if what you do is provide incentives in the contract that say you will provide this kind of quality system and you will show these kind of quality outcomes and those kinds of things, you can build incentives to really develop a quality system. And I think the other thing he said, frankly, was if you start an at-risk system, don't do anything but fund it at least at the same level it was the year prior, otherwise you set it up for defeat, and that's one of the things we...mistakes made in the reorganization of Children and Family, is the money went down, responsibilities went up, and became kind of a setup for defeat. []

SENATOR CAMPBELL: Mr. Hansen, do we have...and I'm going to separate out here the behavioral health segment of the children and youth who need help from those who might just be in the child welfare system. []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: Because it seems to me that in the state we've clearly said, on the child welfare side, we want to get to the point where the child is safe, that we can stabilize the family situation, and we can create permanency... []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: ...for a child in an abuse/neglect situation. What is that, in your estimation, on the child and youth behavioral health side? []

TOPHER HANSEN: What is...? []

SENATOR CAMPBELL: Those long term...I mean in child welfare, an abuse/neglect

situation, we really are trying to get where the child is safe,... []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: ...is the family in a stable situation, and do we have a sense of permanency for that child,... []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: ...either in with their family or a foster family or an adoptive family. Obviously, that's the sense but that's the permanency goal here. On the behavioral health side, what would be those two or three overarching goals that ought to be there for children and youth? []

TOPHER HANSEN: Yeah. You know, the system for youth in the behavioral health side has, at least in my particular experience, has not been run through the behavioral health side so much. We've had just a fractional piece of our total actually be behavioral health dollars. Occasionally we have child welfare dollars in there and it mostly has been Medicaid. And so the...there is...that there isn't as much direction and goal setting, from my experience, on the behavioral health side with regard to those goals. Certainly our outcome goals are similar to what you just described, which is we want the child to be safe and so, to the extent a child is in our treatment program and is moving back to a situation we think is unsafe, then we will begin to work, and we work with the families as much as we are able to, and we try and make a transition back that won't harm that child and that promotes their welfare. But we don't have access to the parents except in brief family therapy, which often isn't enough, and then we don't have any follow-up services. And that really hasn't been funded. That's kind of why we had the outpatient service, is to the extent we could connect youth and their family into outpatient because they needed some follow-up care, we would have that available and use that. But in my experience, there haven't been the same kind of system goals articulated in that

behavioral health side. It hasn't had nearly as much to do with all that as in the Children and Family Services arena. []

SENATOR CAMPBELL: Because it would seem to me, if I've listened to you carefully this morning, you've really tried to articulate to us that the best thing that we could do for a child and youth at that point is to ensure that they're in the very best care solution to start with and not have to have a point at which we go to lower levels and then they, you know, it's like you have to get worse and worse until you get to what might have been the most appropriate care for you at the beginning. That, I fear, on the behavioral health side that we are not taking that step,... []

TOPHER HANSEN: Absolutely. []

SENATOR CAMPBELL: ...ensuring that the child and youth is at the very best that they can have at the beginning and not just a lesser care until they get worse. []

TOPHER HANSEN: Absolutely. And that's been my experience in 17 years and why I said we have been...while clinically we have wanted to develop a continuum of care within our agency, our fear has been, to the extent we develop...and this goes back to ValueOptions and all the way through, our fear has been that if we develop a lower level of care what will happen is, instead of referring, because we provided...have provided that co-occurring treatment and there wasn't for many, many years there weren't other services or programs offering that, so our fear was it would be driven into that lower level of care... []

SENATOR CAMPBELL: Right. []

TOPHER HANSEN: ...and defeat the whole residential treatment program. And so we just did the outpatient and residential levels. []

SENATOR CAMPBELL: Got it. I understand that. []

TOPHER HANSEN: That's all we developed. But I guess to your point, the analogy of going in to the mechanic and you say my car is going like "ticka-ticka-ticka-ticka-ticka-tick" and they say, well, let me fill up the tires and we'll see if that works, and of course you don't do that. And what you want them to do is assess what the issue is, why it's going "ticka-ticka-tick," and then I want my mechanic to say, and by the way, your brakes are way down, too, and you really ought to attend to your brakes. So assessment is the most critical piece up-front to understand what the issues are and what the best fit for treatment is. That is supported nationwide in research in terms of, again, not defeating a child or an adult by putting them at too low a level of care and by getting them the right service at the right time. []

SENATOR CAMPBELL: Senator Avery, you've been trying to jump in. []

SENATOR AVERY: Thank you, Senator Campbell. You made a statement early on when you sat down that I think is stunning in its implications. I think you said that the system is moving toward outcomes that are less focused on what is best for youth. Am I right? []

TOPHER HANSEN: What I said is the system doesn't have a goal on...we don't have a measure of the outcomes of youths. We're focused on process indicators. []

SENATOR AVERY: Okay. So we're not focusing so much on treatment but process. []

TOPHER HANSEN: Yeah, the numbers of how many kids... []

SENATOR AVERY: All right. []

TOPHER HANSEN: ...are in out-of-home placement or state wards. []

SENATOR AVERY: Well,... []

TOPHER HANSEN: That has nothing to do with anything in terms of kids or families getting better. []

SENATOR AVERY: That's stunning. That is stunning. And I think Senator Dubas had a beautiful metaphor when she said we're pulling at separate ends of the wagon. What we have not done...and you said you were going to be blunt. I'm going to give you an opportunity. We talked about one end of that wagon, which is treatment. The other end of that wagon, I think you would agree, is the state. The treatment providers are on one end, the state is on the other. What are we pulling on? Cost? []

TOPHER HANSEN: Families. []

SENATOR AVERY: No, what's the... []

TOPHER HANSEN: What's the driver difference? []

SENATOR AVERY: ...what is the force that's tugging at that other end of the wagon? []

TOPHER HANSEN: It's the piece I said earlier. There's business and clinical decisions and I think that there's more emphasis on the business side, on the cost side, in the state's decision making about what we're doing rather than on the clinical side. And the irony of that is if you do clinical well you'll save money. []

SENATOR AVERY: So we're pulling at separate ends of the wagon. Providers are pulling in one direction, saying we want what is going to be best treatment for the youth. The state is pulling the other way, saying we want less cost. And this set of objectives are in opposition to the other side because sometimes you are going to have to pay

more to get the outcomes you need. []

TOPHER HANSEN: Uh-huh. []

SENATOR AVERY: Am I right? []

TOPHER HANSEN: Yeah. Yeah, I think in broad stroke that's correct, that if your sole focus is the business side of it, is the money side of it, and you don't have systems or indicators set up to go after the quality side, the clinical quality side, then you're going to get lost in the business piece and it won't really have anything to do with how families are doing. And ultimately what that means is then kids become adults in the system. I mean I can go...I can go right now to our adult residential programs, we have two of them, and I guarantee you every adult in there was a kid in the system and that they started drinking and drugging when they were eight, ten years old, and 100 percent of the folks, and right now there are about somewhere in the neighborhood of 36 people that we could go look at, and 100 percent of them would say they have mental illness, they are addicted, and that they have been through the system as a child. And then many of them have never had the trauma in their life dealt with until now and many have not had the mental illness and the addiction pieces dealt with at the same time until they were an adult. So what we've done is, in my estimation, is we've spun our wheels and spent a lot of money getting them to this point, and what we really need to do is way back here--because the sooner you get them the better--and way back here we need to do good assessments for people, and I see a lot of good assessments done in our community, not 100 percent but a lot of good assessments that really are stem to stern, really understand the child and so on. And to intervene and provide the necessary treatment there so that child does not become an adult ought to be our goal and is a victory for us. And that's where I say, this is a long-term effort and you will save money down the road by having that child better. And if what we do is do the same thing we did with all the adults and have them go through treatment program after treatment program after treatment program, then we're spending a lot of money we don't need to. []

SENATOR CAMPBELL: Senator Coash, do you have a question? []

SENATOR COASH: Yes, thank you. Topher, I'm struggling with something here. Right at the beginning of your testimony you said, you know, a family will come in for services and your...you know, this group of trained clinicians will recommend a level of care and, you know, the data from Dr. Schmeeckle says those levels of care aren't being authorized and so something else is being authorized. And then kind of what I heard you say was that is a key driver in some of the problems we're seeing. Is that accurate? []

TOPHER HANSEN: That's one of the problems they're running into, is that an assessment for level of care that's denied and they're put at a lower level. []

SENATOR COASH: Okay. Because...and, you know, Doctor... []

TOPHER HANSEN: Schmeeckle. []

SENATOR CAMPBELL: Schmeeckle. []

SENATOR COASH: ...Schmeeckle's data... []

JOYCE SCHMEECKLE: You can say Joyce. (Laughter) []

SENATOR COASH: Okay. Thank you. Joyce's data is telling us that, you know, even residential is being authorized at 89 percent and outpatient at 98 and day treatment is being authorized, 94. Those are pretty high. The Magellan data that we got at our last hearing is saying that, for example, inpatient requests are being approved at 98 percent so...for an example. So I'm getting two different answers. From providers I'm hearing that we're not getting the service to the families that are...that we're asking for, and

other data is telling me that most of them are getting the service that is being asked for. And so I'm fairly confused about why I'm seeing that. Does that make sense? []

TOPHER HANSEN: Uh-huh. Well, no, it doesn't. I mean, yes, it does and you're in a good group because most of us don't understand it either. That what I can tell you, again, just my own personal experience, is the number. We have zero kids on our wait list right now, zero, and we are about half of where we typically have operated up till July 1 of this last year. And so we know that the numbers are coming down. Now where are the kids, so is our question. And I, frankly, I asked Magellan where are the kids and they said, you know, we don't know either. That what we see is residentials come down but we really haven't seen community-based go up in the same way that we would have expected. We really don't know where the kids are. And so it seems all of us are kind of wondering the same question, which frightens me a little bit that we don't know (laugh) where the kids are, that we've taken these actions and we don't know. And so what those numbers mean exactly, you know, I wish I could tell you but I just don't know. All I can tell you is my experience. I do know from reading that report and from other providers anecdotally who are saying we are really encouraged to refer to lower levels and not refer to residential treatment and that that has been kind of a push in the system. And, you know, this is what the state said to us a long time ago. We're going to...we're going to push it so everything is down in community-based and we're in less out-of-home placement. And my thought on that was--I was curious about it--does that mean that then we're going to have less residential treatment and then why would that be? What's the alternative? Because if we have a kid in outpatient treatment of some level then we were wrong for all these years in putting them in residential. Those assessments are wrong because you should not have a kid in residential treatment that could get IOP or outpatient and be okay with that. And vice versa, if we're putting them at those lower levels when they really need a residential level, that is wrong. So we really need to understand that. But back to Senator Campbell's statement, the assessment is just the critical piece of all of this and that drives the whole system. That is our question when they walk in the door: How can we help you? That assessment is

that question and it says this is how you can help me, these are my needs, and then we need to go find those services and then figure out what funding systems will help cover that. []

SENATOR COASH: So...I'm sorry. So you're not turning...you said your waiting list is zero so you're not turning anybody away for services. []

TOPHER HANSEN: The only reason we would turn anybody away is because we assess them to be a sexual predator at a level that we cannot contain them and that they would harm the others in the program or that their violence level is such that it's uncontained and also would harm people in the program. So it's only threat to the residential community, treatment community, that we would deny admission or if they weren't clinically appropriate. If we have somebody who just has a mental health problem but really has never engaged in substance activity at all, we're not going to put them in a program where people are addicts and have mental illness, because our fear is that then that person might be harmed by that in a way that we don't want. []

SENATOR COASH: But you don't have any families coming to you every day and saying, I got to get my kid in to your services. You say you have zero waiting list. []

TOPHER HANSEN: Well, families come sometimes to say how do I get in, and so we point to different places in terms of the avenues to get in, because they don't have the resources to pay for services and we can't afford to have somebody in our program and be expending dollars and not have some funding source. So what we do is try to help them get connected and we're not connected through the lead agencies, through probation, through Medicaid. We still have behavioral health dollars. We have expanded our avenues as wide as we can, trying to think of creative ways to get families in the door, but it's still a problem for some. []

SENATOR COASH: Okay. []

SENATOR CAMPBELL: Follow-up question, Senator Avery. []

SENATOR AVERY: I want to follow up on the line of questioning from Senator Coash. You did say that it's not uncommon for all of the professionals, the psychiatrists, the psychologists, the...you had an acronym for it, I think it's a licensed... []

TOPHER HANSEN: LMHP, licensed mental health professional. []

SENATOR AVERY: ...mental health providers or professionals to all recommend one line of treatment and they agree and then it goes to Magellan and they decide otherwise. And who are they? Are they professionals or are they desk bureaucrats that don't... []

TOPHER HANSEN: They're licensed, they're licensed individuals as well. The care providers are licensed individuals as well and they have the criteria in front of them but so does the evaluation group. That, the group situation, is less the rule because that's really expensive, and more what the situation is, is that one licensed professional will do an assessment and make a recommendation and then it goes to the care provider at Magellan who...the reviewer who then decides. That's the more common situation. There are situations where psychologists/psychiatrists individually, licensed independent mental health practitioners, which is a little higher level, or occasionally out at the youth detention facility here in Lincoln that a group will provide an evaluation and that's the experience I told you about when they contacted us and said, hey, we have somebody, and then it was overruled, so... []

SENATOR AVERY: And you have a unanimous conclusion that this line of treatment is what we need and then Magellan says, no, that's not what you need, we're going to go this way. And it's always a lower, less expensive treatment program? []

TOPHER HANSEN: Yeah, I have never been a part of a decision where they said, you know, that's not appropriate, you need hospitalization. That would be the next level up for us. I've never seen that happen and usually what it is, is a lower level of care that's less expensive. []

SENATOR AVERY: In your opinion, is cost driving this and not treatment? []

TOPHER HANSEN: Yes. []

SENATOR AVERY: Thank you. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: I guess I would just pick up where Senator Avery left off and, again, that goes back to the philosophies and the orientation, and we just aren't operating on the same page, but ultimately we hope that our goals are the same. Now I lost my train of thought here. In the conversations that I've had with various mental health providers, they are at that point where I'm not even going to ask for residential treatment because I know I'm going to be denied, so I'm going to start back here even though I know that's probably not appropriate. I would agree 100 percent that we should be looking at how do we reduce residential treatment care, recognizing there are a certain segment of the population that that's what they need. But if you were going to set up goals as short, intermediate, and long, in my mind you would set up reducing residential treatment as a long-term goal. And so how do you get to that long-term goal? You get kids in quicker at an appropriate level of care so that ultimately they don't end up having to need that. Would you agree with that line of thinking? []

TOPHER HANSEN: Yeah. And even the first thing you have to do is you have to get an infrastructure, because you have a state, you know, that is long and wide and we have lots of folks, and so you have to get an infrastructure that is manageable in terms of

your costs, your business side, and then understanding what the clinical side is. And again, that would require that we then understand what our goals are, what are we trying to do as a state. And in broad way we want families and youth to be healthy and productive in our society, but more specifically I think we need to understand that. Then I think you set up an assessment and a treatment system that has that in mind. I think all providers would say, to the extent we can get people better and run ourselves out of business, that would be a good thing. It isn't that we're doing this because we want anything other than for people to be better, and so we would set about that goal. But we just need to be able to do it at the right level and not, as I said, as a society we can't be inefficient in this and I fear that we're being inefficient because we're...it's more of a cost-driven system than a care-driven system. And we can do those care-driven systems. They are happening elsewhere. But we need to understand what they look like and how to do it and maybe get some help in understanding how to really implement one on a long-term basis. []

SENATOR DUBAS: So it would take us time to get to that point where we aren't actually needing the residential treatment. It's not going to happen in this year or next year or even the following year. Another one of the things that I see, you know, we're a political body. You know, there's constant change and turnover. How do we...where do we get some continuity so that when we set up these goals, when we do this system analysis, when we know the direction we want to go, how do we make sure that as administrations change, as the Legislature change--everybody always comes in and wants to reform something, you know, everybody wants to put their mark on it--how do we build a flow and a continuity into a political system? []

TOPHER HANSEN: Uh-huh. Well, I think it's hard. I think that to some extent it falls on the Legislature. I think to a great extent it falls on the Governor as CEO of the state. And I think the way to do it is do it well. If you do something well and that it works and so you can show your outcomes, then in future legislators, future Governors and so on see a system that really is humming and there is no need for reform. Because we can produce

what our outcomes are. We know how our kids are doing. We know how the families are doing. We know what our costs are. And so if we set up a system, that does take some time to develop, that you can track those things, I think that becomes less susceptible to reform. The reason that we reform everything is because it's not working. And so sometime we just need to grab on and help develop a system that really does work. I think we are in one of the greatest positions in the country to do this and that I think the values of the state of Nebraska are such that we do good thing, we do great things, and we're only 1.8 million and that is a workable number to be able to put a system together that works. In states that have many, many, many millions of people, it is much more difficult to wrap your arms around. We can get our arms around this one and do it. We just have to have the resolve to get there. []

SENATOR CAMPBELL: Mr. Hansen, and I realize it's probably too early in the system to know this but if what some of us believe is true, that some of the children that would have been in residential care are now being treated more in the child welfare section of it. Are we...are you tracking any of these children and youth where not...that was not a good placement and that they're going to, you know, eventually come to you and need that? Are we seeing any of that movement? I'm sure that's one of the questions that we would want to look at in terms of where are...not only where are the kids now but are they coming back. Because that's going to show us some outcomes here if what we think is working is working. But it's probably too early to tell that. []

TOPHER HANSEN: Yeah, we don't know where...I mean it's sort of where are the kids that you're not seeing. And so we don't know where the kids are that we're not seeing... []

SENATOR CAMPBELL: Right. []

TOPHER HANSEN: ...and that they get diverted off. We can barely muster the resources to do follow-up care... []

SENATOR CAMPBELL: Sure. []

TOPHER HANSEN: ...up to 90 or so days. And what we know, though, is that we track those kids to see how they're doing and one of the things that we know from that, that would be of great benefit that really doesn't exist in the behavioral health world that I'm operating in is that follow-up care, having like a case manager and things like that. There are community treatment aids and systems like that that, frankly, are difficult to involve ourselves in. If we had something more that is akin to what the adult system has, it would provide good benefit. The FYI and those programs, frankly, the behavioral health side doesn't access much. We don't see that wraparound care so much. And I've never really understood why that was but I just know that the residential treatment providers in the community don't tend to see that interface much. Those things are good ideas. It's an efficient use of money, I think, to have a wraparound and a total care and a relationship with a child and a family that follows along, but you need some of these insertions of high levels sometimes like residential or maybe it's outpatient or IOP or things as somebody kind of moves through that treatment process. []

SENATOR CAMPBELL: I do know from one of the providers in terms of outpatient treatment and therapy and counseling was in to see me this week and some of their waiting list numbers on outpatient or counseling are growing, and so there was some concern there. So perhaps what we need to do is not only talk to the providers at your residential level but also those providers who are doing the outpatient and some counseling in the community to see whether their numbers. If Magellan doesn't see them there, perhaps it's because they're on waiting lists and haven't been asked for. But I mean I'm concerned that...and maybe we go to the child welfare system and we say, okay, how many people came to you that might have or were placed on a lower level of treatment and no foster therapeutic home would take them and they're not working well in shelters and we can't find anybody to take? You know, I always use my son, Andy Campbell, but you know nobody is going to take Andy at this point when Andy should

have really been in a residential treatment center. I'm trying to figure out how we track those young people to know if we had done the right thing at the beginning... []

TOPHER HANSEN: I agree. []

SENATOR CAMPBELL: ...we would have saved ourselves an enormous amount of that person's life. []

TOPHER HANSEN: Exactly. And as I said, the thing that I...that I see in adults when they come in and have been through other treatment programs at lower levels, where it just is too little but is what's forced kind of thing, that they feel like they're the failure and that's unfortunate. []

SENATOR CAMPBELL: Right. Because the statistics here in terms of how many are denied and, you know, you're watching one trend, we're watching another over here for Magellan,... []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: ...the point being, though, is it would be really nice to be able to go back to those folks who were not recommended for residential treatment and look at that and say was the lower level of care successful. []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: Because a lot of people in this room, probably we all would believe anecdotally that they may not be;... []

TOPHER HANSEN: Uh-huh. []

SENATOR CAMPBELL: ...that then they may languish there and have to come back eventually. Senator Nordquist is nodding. I mean I don't know how we get at that statistic but perhaps that is one thing that we need to do some talking with some of the other providers and see if we can at least anecdotally come to some resolution, because that would help us as policymakers determine where our resources ought to be. []

TOPHER HANSEN: And you can see from Joyce's numbers that the outpatient has come up a little bit and residential gone down. []

SENATOR CAMPBELL: Yeah. []

TOPHER HANSEN: But as I said, if that's a direct relationship, there's something wrong with that. Because either we have the wrong people in residential or we've got the wrong people in outpatient. Those should not be that connected. What you'll find in people who are put in lower levels of care, if you take the whole treatment population, generally you'll find people who need residential, if they go to an outpatient program they won't get better. Occasionally some will and some, whether you put them in an outpatient treatment, residential or not, will get better by themselves. That's called spontaneous remission. There is a portion of the population that says, you know, I really have a problem, I need to change my behavior, and they change. At the levels that we're seeing, where kids are mentally ill, untreated, they're addicted, they have difficult childhoods and family backgrounds and so on, that is very rare. But in the broad treatment population, in substance in particular, the substance arena, you will see spontaneous remission as a factor and occasionally then people who are in lower levels of care start responding to that, and good if that's the case. But the clinician's best assessment at the time is this level of care is going to be necessary and, therefore, let's head that direction. So it isn't that you won't find those other two to have some success, but it is not the rule by any means. []

SENATOR CAMPBELL: Other follow-up questions? Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. And I don't know if this question can even be answered but, you know, there's such a difference between treating mental disorders versus physical disorders and oftentimes with mental issues you're not just...it's not just the patient, it's their support system. []

TOPHER HANSEN: Uh-huh. []

SENATOR DUBAS: It's their family. For children, how many...you know, I don't know how to ask the question because I don't know if it can be answered. How many of these kids come from families that need treatment too? How many of these kids it's not just their issue, it's the entire family's issue? And do we have the appropriate treatments in place that we're treating the entire family, not just the child? []

TOPHER HANSEN: And my response is in no way empirical and is anecdotal hearsay at best, and what I can tell you is my experience is the majority and maybe even the supermajority, that range. So a 50 to two-thirds percent kind of range have families that really need a lot of care themselves. We see a lot of substance use in families, of untreated, undiagnosed and untreated mental illness, and it...there really is a long history. With the other percentage, we see families who are, by the trappings of society of the house and the cars and the picket fence and good jobs, but maybe have a child that has a mental illness and mental illnesses don't announce themselves. They just creep up over time and begin to manifest in ways and nobody knows what it is or how to deal with it or what's going on. And it becomes a real struggle to figure out what you're doing and what you need to do to respond. So they have those situations that they're wrestling with. And occasionally it is a situation where the child then gets better and then, as a family system, what you do is you begin to help the family understand how to integrate the child's needs in parenting them, and so you kind of readjust and retune everybody to accommodate that illness and people move on. Same way with diabetes,

you know, you don't you have it until something is wrong, something is wrong, something is wrong, something is wrong, and then you go to the doctor and go, oh, my gosh, we have diabetes. Well, then the family system, by and large, changes because you have a person that has medical need, has constant daily activity needs, and family members often need to help in monitoring and so on and forth. It's not much different than that in many circumstances. But we do see a fair amount of trouble in families that helps...that needs resolving. In fact, I can think of a couple situations off the top of my head where a youth has been in our residential program and that has really...kind of that bubble has really freed the child to begin to do all the kind of therapy they need and then they begin to engage and motivate the family into getting better, and even though the family is coming in, that youth is the catalyst for everyone doing that. But it really took that kid to help initiate all that. So it's a variety of experiences but if you talk to other providers they would say similar things, that probably more than 50 percent of the time we have family dynamics and circumstances that also need attention, and then the other portion of the time it's just everybody adjusting to the new circumstance, which is we have a child who's addicted and we have a child who has some level, whatever it is, of mental illness maybe or it's maybe one or the other and we need to fine-tune our family system to help them accommodate that. []

SENATOR DUBAS: I just remember not too long ago I have someone I'm very close to who works with juveniles and his comment was on family weekends, he said, I really wanted to send the kid home and keep the parents or keep the support system, he said, because that's where the problem was. []

TOPHER HANSEN: Yeah. []

SENATOR DUBAS: And so, you know, I know with probably a lot of our kids it needs to be a family approach and I don't know if we're really there with a lot of our treatment. Thank you. []

TOPHER HANSEN: Yeah. And fortunately, a lot of...we have families that want to be involved. That's the good news. Kids always want more than what some families can offer. But we have...I remember a phone call on our family day where we kind of have, you know, food and, you know, that kind of thing, just fun, and they called me up and said, we have twice as many family members as we thought we were going to have, what do we do? And I said, rent tables, buy more pizzas, you know. I mean that's a good thing. That's the problem you want to hear about because then you know everybody is engaging, so. []

SENATOR CAMPBELL: Any other follow-up questions. Thank you very much, Mr. Hansen. []

TOPHER HANSEN: Thank you for inviting me... []

SENATOR CAMPBELL: And I'm assuming that... []

TOPHER HANSEN: ...and tolerating me. []

SENATOR CAMPBELL: Oh, well, I know that Mr. McCarville was very sorry that he could not be here but I know that both of you have tried to represent certainly the residential treatment folks and your concerns, and we'll be talking to you as to continuing the study, that part. []

TOPHER HANSEN: And I think your comment about having child welfare providers come up, even other behavioral health providers, and probably most importantly to hear consumers, family members who have really run into that face to face, because I am not that person and only know it anecdotally. So I think that's good information to help understand what this looks like. We're all trying to do that. []

TOPHER HANSEN: Thank you. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR AVERY: Before you sit down, I just wanted to say I appreciate very much your candor and your understanding of this issue, and we need that. []

TOPHER HANSEN: Thank you. Well, I think the more we get the truth on the table the better the outcome will be. []

SENATOR AVERY: Yeah. []

SENATOR CAMPBELL: Okay. We will take a ten-minute break and then we will come back. Liz Hruska will give us an idea where we have spent the LB603 money. []

BREAK []

SENATOR CAMPBELL: Okay. We're ready? Okay. We're going to start with the second, as somebody said, for the second half. I don't know that we're going to be quite here that long, but Liz Hruska is here to give us an update on where we are on the LB603 money, so we'll turn it over. Thanks for coming, Liz. []

LIZ HRUSKA: (Exhibit 2) Good morning, Senators, and thank you for inviting me to update you on the appropriations for LB603. As you are all aware, LB603 was a combination of five bills to address issues that came to light with the safe haven bill, and several members of this committee were introducers of those bills. The Legislature appropriated close to $6.4 million in General Funds in the current fiscal year, $9.2 million for fiscal year '11 to address the behavioral health issues. And on the last page of your handout is a summary chart of the appropriations that I will be going through. First bill is LB136, which Senator Avery had introduced. In the current fiscal year almost $2.2 million in General Funds, and a total of $7.9 million were provided to increase the

eligibility for the Children's Health Insurance Program from 185 percent of poverty to 200 percent of poverty. The implementation began on September 1 of 2009. In the first two months following the increase in eligibility, the largest enrollment increases occurred. Enrollment grew by 3 percent each of those two months. Since then, the growth has continued but at a slower rate. The total growth in enrollment from August 2009 to May 2010 was 3,213, or a 13 percent increase in the number of children eligible. The prior fiscal year only grew by 1.2 percent. And Senator Nordquist had asked last week if there could be a distinction between the new eligibles and the continuing eligibles, and I had contacted the department and they really aren't set up to capture that because it was really just a continuation, it's not a separate category. But in light of the dramatic growth in the program versus the prior year, I think you can see that the driver really is the increase in eligibility. []

SENATOR CAMPBELL: And I'm going to stop you right...any question on that part? Did we cover your question, Senator? []

SENATOR NORDQUIST: Yeah. Yeah, Liz and I had talked about it. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR AVERY: Do you have any knowledge of the outreach programs associated with that? []

LIZ HRUSKA: No. []

SENATOR AVERY: What are they doing to advertise it and make people aware they're eligible? []

LIZ HRUSKA: I know they do do some outreach but I didn't specifically ask them and I don't know if they've changed that from the past, so I really can't address that. []

SENATOR AVERY: Uh-huh. That seems to be a crucial part of this program. If you're not actually providing the eligible people with information, a lot of people don't know they're eligible, a lot of families. []

LIZ HRUSKA: Correct. []

SENATOR AVERY: And I presume there are some families that are eligible, know they're eligible but choose not to participate. []

LIZ HRUSKA: Right. []

SENATOR AVERY: My own understanding of this is a lot of people do not realize the program exists and that they qualify. []

LIZ HRUSKA: Yeah, and that...I'm sorry I didn't check in on that particular aspect of the program. []

SENATOR AVERY: There is one way to deal with the outreach issue and that is some states have gone to an automatic enrollment program where their Department of Revenue, which collects tax information, they know which families are eligible so they notify them. We've kind of been reluctant to do that here because tax information is sensitive. []

LIZ HRUSKA: Right. And the agency, I think to do that sort of a program, which I have read about it in other states, I think the agency would need legislative authorization to do that. []

SENATOR AVERY: I know. I considered doing that last year and then backed away because of the sensitivity of tax information. []

LIZ HRUSKA: Right. []

SENATOR AVERY: But I'm thinking still. Thank you. []

SENATOR CAMPBELL: But even with...I mean not knowing what that outreach is, there's a significant percentage. I mean I'm pleased. I didn't think it was that high over the course of that time, so that's good. []

LIZ HRUSKA: Yeah. []

SENATOR AVERY: But we're still underspending. []

LIZ HRUSKA: Right. []

SENATOR CAMPBELL: We're still underspending in that amount but... []

LIZ HRUSKA: Right. When the department and I both did our fiscal notes, we assumed that eligibility in fiscal year '10, the current fiscal year we're in, would be about 5,400 kids and we're at 3,200. So we're not likely to reach that because these figures went through May. So we are underspending. But even prior to that, CHIP in the prior fiscal year with that 1.2 percent utilization growth, was also underspending and the why question that you talked about earlier and now I can't really give you that. I mean we just make estimates based on the best information that we have and, you know, sometimes they're high and sometimes they're low. That's just part of what trying to do projections entails, so...but, yes, there are currently savings in the CHIP program because it hasn't grown at the pace that we had anticipated, although it did grow at a fairly significant pace. []

SENATOR AVERY: And that means we're not leveraging as much federal money as we

could. []

LIZ HRUSKA: Right, because it's a match program. []

SENATOR AVERY: Uh-huh. []

LIZ HRUSKA: For, you know, every $1 we put in we get a higher amount back from the federal government, right. []

SENATOR CAMPBELL: Liz, we looked at that at one point and tried to figure out, in the years that we've been...we've had the CHIP program, what years we actually did use all of the money. []

LIZ HRUSKA: Right. []

SENATOR CAMPBELL: Can you remember, was it initially at the beginning but then we got an increase in terms of the federal dollars? []

LIZ HRUSKA: Right, we have a cap. []

SENATOR CAMPBELL: And then we'll get another one? Because, Senator Avery, that's part of that. I mean we reached a level, we used the funds, but then we got...we jumped up in terms of what the federal allotment was. []

LIZ HRUSKA: Right. Right. When CHIP was reauthorized, our...at the federal level, unlike Medicaid which for every $1 match we get the federal match and it's uncapped, CHIP does have a capped allotment per state. There were a few years back, I don't remember when, when we either would have...I think we did exceed our allotment, but other states were underspending so it got reallocated. Right now, with the reauthorization of CHIP, I think it was almost a doubling of the federal allotment, so we

really aren't at risk of triggering that. And in the CHIP reauthorization there's also additional federal money that states can tap into which prior to the reauthorization did not exist. So I mean there's kind of a safety net at the federal level so that states won't run out of allotment. []

SENATOR CAMPBELL: Yeah. But I think Senator Avery's question is a good one, that we can follow up with the department and ask what the outreach efforts have been just so that we know. Senator Nordquist. []

SENATOR NORDQUIST: Liz, were you able to at this point in time calculate any kind of estimate or has the department told you roughly how much total dollars they're below spending projections for the year? []

LIZ HRUSKA: I've looked at it. It's kind of hard to tell because sometimes the fund mix gets kind of off depending on when the claims are reflected on the accounting system. I'm trying to even remember. I have to double-check that because... []

SENATOR NORDQUIST: All right. []

LIZ HRUSKA: ...I don't want to go from my memory, but I think we're, oh, 10 percent or more maybe behind where we are in the year versus where the expenditures... []

SENATOR NORDQUIST: How much dollars, like roughly? Any idea what that would calculate to? []

LIZ HRUSKA: Yeah, and I would need to look... []

SENATOR NORDQUIST: Okay. []

LIZ HRUSKA: ...at that. I should have...I probably should have brought that and I didn't.

[]

SENATOR NORDQUIST: That's all right. []

LIZ HRUSKA: But I did look at the expenditures through May and we were running behind percentagewise versus the... []

SENATOR NORDQUIST: About 10 percent. []

LIZ HRUSKA: ...percent of the year that had lapsed already. []

SENATOR NORDQUIST: Any chance that's enough to cover prenatal care? (Laugh) []

LIZ HRUSKA: Um, that... []

SENATOR NORDQUIST: We can talk later so don't worry about it. (Laughter) []

SENATOR DUBAS: Another committee, Jeremy, another committee. []

SENATOR AVERY: That's a policy decision. (Laugh) []

SENATOR CAMPBELL: However, Senator Nordquist, I continue to look for this, so that's okay. That's a great question. Okay, Liz, sorry, we'll go on to the next one. []

LIZ HRUSKA: Next bill is LB346 and that set up a Family Navigator Program, a Children and Family Hotline, and new postguardianship services, and last month you received a report about those services so I won't go into any further detail on those. So you are aware, the programs are underway and they are expending at approximately the appropriated levels. []

SENATOR COASH: I do. I think you can answer this, Liz. My assumption would be that the 2.9 and the 4.9 included a significant amount of startup costs to get the Navigator and the hot line up and running. And is that the appropriation? []

LIZ HRUSKA: Well, they're contractual costs so I mean like with the postguardianship services... []

SENATOR COASH: Okay. []

LIZ HRUSKA: ...the agencies have hired like caseworkers. []

SENATOR COASH: Sure. []

LIZ HRUSKA: I'm not sure, they may have had some up-front costs but I'm not sure that they would be a significant part. I think, you know, the 2.9 was a half-year assumption and then... []

SENATOR COASH: Uh-huh. []

LIZ HRUSKA: ...we assume full year implementation next year. So I don't think the startup costs for these type of services would have been that much. []

SENATOR COASH: Okay. []

LIZ HRUSKA: They're probably...Boys Town who has the hot line contract, they already had a hot line so I mean they were already in the business. They may have had to add to their infrastructure and obviously they would have had to hire more people but I'm not sure those infrastructure costs to get more phone lines in would be all that that's... []

SENATOR COASH: Is a big part of the appropriation? Okay. Thanks. []

SENATOR CAMPBELL: Any other questions on that one? Okay.

LIZ HRUSKA: And the next bill is LB356, which increased support to the mental health regions to expand services to children. That was Senator Dubas' bill. The Legislature provided $500,000 in the current fiscal year, and that money is under contract with the regions so it will be spent. Next year, that will increase to $1 million. And a provision in law exempted these funds from a county match requirement that some other aid to the regions does require. And you will be getting a presentation on how that money is being spent this afternoon, so I will leave it to the experts there to elaborate on that. Next bill was LB601, which was a bill Senator Nordquist introduced, and LB601 has two parts. They both deal with payments of Medicaid, one for subacute care and the other for secure residential services. In the subacute area, the state had been covering subacute services in hospital settings for all Medicaid-eligible persons. Then, in December 2008, the Department of Health and Human...our Department of Health and Human Services notified the Legislature that, beginning July of last year, they would only be covering subacute services for patients who were involuntarily committed. LB601 allowed for those services to be covered for both the voluntary and involuntary commitments, and some of the providers we had met with said the voluntary commitments ultimately would have probably been involuntary commitments. They would have just had to go through the process. So this avoided some people having to go through that additional step to maintain Medicaid eligibility. When the department notified the Legislature that they would discontinue coverage of patients who were voluntary commitments, they did not come in and request a reduction to their budget. So for this portion of the bill, there was no A bill for it, because my assumption was the funding was already provided there since we did not take any action to take it out. The subacute services in nonhospital settings that this bill expanded Medicaid coverage to, we did have an appropriation of $143,000 General Funds, of $428,000 total funds. And as of April 1 of this year, those services are now being reimbursed. In the secure residential area, those services have been covered through the behavioral health regions with approximately $4.2 million in

state General Funds. And at the time the bill was introduced, the estimate was at about 70 percent of current clients would be Medicaid-eligible. And based on that assumption, we reduced the budget by $977,000 for aids to the region to use that as the Medicaid match. And we assumed that the service, the Medicaid service, would begin in January of 2010. However, these savings have not been achieved for several reasons. And the first is the approval from the Centers for Medicare and Medicaid--CMS--took a little bit longer than had planned. We didn't receive it until March of this year, with an effective date of April 1. So that delay did reduce the savings, but it's no longer an issue because we are allowed to cover the service. A second issue is further delaying capturing the federal funds, and that has to do with the service delivery structure. CMS has raised some issues and the department is asking for further clarification. And the issue is...and just for background, facilities that are defined as institutions for mental diseases or IMDs are not eligible for Medicaid reimbursement. And IMDs are facilities with 17 or more beds. The state has two secure residential providers. One is Telecare, and they have physically separate units of 16 beds apiece--one is in Douglas County and one is in Sarpy County. CMS has cautioned the state that they may look at Telecare as being a single provider and, therefore, not eligible, because they would be tripping the more-than-16-bed criteria. And the state has written to CMS, saying they believe that they do meet the secure residential facility and then not the IMD because they have their own medical director, each program has their own program director and administrator, and they're accredited and licensed separately. There's another provider of service in Columbus and Norfolk--Behavioral Health Specialists--and they have two facilities, one in Norfolk with 16 beds and the other with 20 beds. Only the Norfolk facility would be eligible for secure residential. But similar to that, our department is asking for clarification as to whether or not they will consider the Norfolk facility separate from the Columbus one. And like Telecare, each facility will have their own medical director and they're both accredited and licensed separately, but Behavioral Health Specialists is a little different in that they will share an executive director between the two facilities. So we are awaiting clarification before reimbursing the providers under the Medicaid program. And another issue, which I think is a smaller issue, is whether or not

CMS will look at these providers as private providers or public providers. If they're public providers, they would not be reimbursed, but they...although they do receive funding from the regions, they are not under the governance of the regions. So I would think, hopefully, CMS will deem them to be private providers. In fact, Telecare is a private corporation based out of California, and Behavioral Health Specialists is a nonprofit. So I think, structurally, that can be argued fairly strongly. And as I had mentioned earlier, we reduced the budget by $977,000 in the current fiscal year, assuming a January 1 Medicaid reimbursement date. That did not come about. The regions are being held harmless. This current fiscal year the agency was able to reallocate funding from some contracts that they weren't fully utilizing the funding they had set aside for. However, if this situation continues into the next fiscal year or if somehow CMS will not allow the current providers to be reimbursed, the Legislature may need to look at this issue again and adjust the budget, since the intent was ultimately to keep the providers held harmless once the Medicaid reimbursement came about. []

SENATOR CAMPBELL: Senator Nordquist. []

SENATOR NORDQUIST: Just an update. Our office, in the last week or so, has contacted Senator Nelson's office, and they're going to try to encourage CMS to hurry along a response to Director Chaumont's letter, by the end of the month. So hopefully we can get this resolved by the start of the fiscal year. But that's about where we're at. []

LIZ HRUSKA: Okay. []

SENATOR CAMPBELL: That would be great. []

SENATOR NORDQUIST: Yeah. []

SENATOR CAMPBELL: Thank you. Any other questions on this segment? Okay, Liz. You're on a roll here. []

LIZ HRUSKA: (Laugh) Then the final bill is LB603, the Behavioral Health Workforce Act, and that set up a Behavioral Health Education Center at the University of Nebraska Medical Center. And the bill called for establishing two residencies each year, until a total of eight additional residents were in the program. It also sets forth setting up six interdisciplinary health training sites, and those would be phased in, over time, and four of those would be located in counties with fewer than 50,000 people. The original appropriation in the A bill for this was close to $1.4 million in General Funds. But during the November special session, the university's budget was cut by $1 million. The reductions were taken from this program and from the College of Nursing in Norfolk. So the Behavioral Health Center, from the remaining funding, received $965,000 in the current fiscal year, or approximately $420,000 less than was originally appropriated. They are proceeding with establishing the center. They have hired a medical director, an education coordinator, and an assistant, and they also have contracted for three program managers, and they will have two psychiatric residents for the FY '10-11 academic year. They will begin interprofessional training of students at the Lasting Hope Recovery Center on July 1 of this year. And over the academic year more than 30 students will be involved in the training. They have also, as part of their planning process, held a telehealth summit, identifying barriers and proposing solutions. They've conducted a statewide needs assessment, and they are working on a baseline assessment of work force issues, academic partners, and telehealth capacity, and that should be done by November 1. They've also secured office space and equipment to support distance training, service delivery, and education. And that concludes my presentation. If there are any other questions? []

SENATOR CAMPBELL: Any questions on that, that anyone has? Liz, you're always so thorough, it's hard to come up with good questions for you. But we seem to be moving along pretty steadily on the goals that have been established by the legislative bills that went into the appropriations. So as long as I think this committee has assurance that we're spending the money and the goals that we had set out to, that's an excellent

report. I suppose we will continue to worry about how the funding of all this comes about when we come into the next legislative session, but at least we can say to our colleagues, what we had intended to do with the money we are doing. []

LIZ HRUSKA: Yes. I think, you know, the presentations you've heard and those coming up, this money really is, you know, doing what you intended to do to address the issues that came up during the safe haven period. []

SENATOR CAMPBELL: It would seem to me, along with Senator Avery's request for some information on the outreach program, we probably need to follow up...I mean, we'll know about the situation with CMS and probably don't need to do that. And we will hear from the regions this afternoon, which I think will be really helpful for us. Senator Dubas had suggested that for the agenda and we thought that was an excellent suggestion. But we may need to go back and talk to...have UNMC come in as a follow-up, because we heard them so early on that it would be interesting to have them come back, because I particularly want to know the outreach in greater Nebraska, because they were very excited about all the avenues they'd opened. So we will do that. Are we missing anything? Is there anyone else that we should be talking to or bringing, that from a fiscal standpoint we need to ensure that we've talked to them and...? []

LIZ HRUSKA: No, I think that covers it, if you have the Medical Center in, and Senator Nordquist will probably stay on top of LB601, as I will also as we shape the budget,... []

SENATOR CAMPBELL: Okay, we'll get the program people. []

LIZ HRUSKA: ...you know, check on that to make sure that the regions are not short of funding that had been intended for them. []

SENATOR CAMPBELL: It's not unanticipated that CMS would have some questions on those two facilities...or the, you know, the two different...because I remember talking

about that and the Health and Human Services Committee, the whole telecare, and whether both of those.... []

LIZ HRUSKA: I mean, just from my lay standpoint, it is kind of odd because...in both the providers, the facilities are far enough in distance that a nurse on a shift isn't going to be able to work in this facility for two or three hours and then move over to the next one. I mean, it would involve, you know, some amount of travel. It wouldn't be efficient. So, I mean...and they are licensed and accredited separately, as the agency has pointed out in their letter to CMS, so I think we have some fairly strong arguments. In fact, I'm actually kind of...again, from sort of just my lay standpoint and understanding Medicaid, why this really was even brought up as an issue. I guess, you know, because it's not like they're on a single piece of property, two separate buildings. They are physically, geographically separated, and licensed separately. So I...hopefully, that will get resolved, and get resolved quickly, you know, so the budget really come in, on target, as we had intended. []

SENATOR CAMPBELL: Any other questions or comments from...? []

SENATOR AVERY: I have one comment. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR AVERY: One of the questions we need to answer somewhere down the road, and I don't expect you to address this, is whether or not the $1.9 million is enough. []

LIZ HRUSKA: Right. []

SENATOR AVERY: And I know in these economic times that's a tough question to be raising, but at the time we passed LB603, we were not sure at that time that we were

even putting anywhere near enough money into the program, and we were constrained by fiscal issues than. []

LIZ HRUSKA: Right. There's always going to be that balancing act. And, you know, whether it's enough or not, I'm sure there's people (laugh) who would debate that. But I do feel like, from the presentations that you've had and from my checking with the department in light of this presentation, that, you know, the dollars that the Legislature put out there really are being put to good use, as the intent is what you wanted. So I think, you know, you should feel good about that, that I think, you know, these programs were, you know...or getting to at least some...to address some of the issues that arose. []

SENATOR CAMPBELL: We were all very clear, though, that that was only phase one. And Senator Avery's comment is well-taken--what would it take, and looking at the system, what do we need? So I'm sure that may be far from $1.9 million, but we'll see. Thank you, Senator Avery. Any other questions? Again Liz, always appreciate your thoroughness. I'm going to give the audience an early lunch out, but not my colleagues. We're going to stay for a little while in executive session, primarily to talk about future agendas and what other information they might like. So I'm going to go ahead and clear the hearing room. We will reconvene again at 1:00 for the presentation on the regions. So you will all get an early lunch out here. []

LUNCH RECESS AND EXECUTIVE SESSION

SENATOR CAMPBELL: We will start and assume that Senator Avery will join us. Thank you, one and all, for the dedicated folks that are here for morning and afternoon sessions. I'm going to go ahead and reintroduce everybody for someone who came new. I'm Kathy Campbell and I'm the senator from the 25th Legislative District. And to my right is... []

SENATOR COASH: Colby Coash, from District 27, right here in Lincoln. []

SENATOR CAMPBELL: And to my left... []

SENATOR DUBAS: Senator Annette Dubas, District 34--Grand Island, Central City, Aurora, Fullerton. []

SENATOR CAMPBELL: And we expect Senator Avery from the 28th Legislative District, which we are in, to join us and to come back. So we appreciate everyone coming. This afternoon's agenda was suggested by Senator Dubas, and so I really appreciate that. In terms of wanting to hear what's happening with all the regions, this is a great place to start. And so we asked Scot to kind of give us an overview of some funding and any comments that you wanted to make. So welcome. Thanks for coming. []

SCOT ADAMS: (Exhibit 3) Okay. Well, thank you very much for having me; I appreciate that. Thank you. My name is Scot Adams, S-c-o-t A-d-a-m-s. And I want to, first of all, thank the committee for its ongoing interest in the topic and the ease with which it is to work with this committee in terms of the relationship between executive branch and legislative branches, and just wanted to acknowledge that and to say thank you to you all for that. I have a handout, a one-page handout that you have that sort of summarizes this portion of things. I had been asked to prepare some remarks with regard to the Professional Partners Program, in particular, and so wanted to, simply again, refresh our memories that there is a half-million dollars in the current fiscal year ending June 30 that was appropriated, and $1 million planned for expenditure in the next fiscal year with regard to this particular program. So that's the dollar amounts that were appropriated to this particular wraparound service, or known as the Professional Partner Program. We start with a little bit of background in context on that sheet that says that wraparound is sort of a generic phrase--term of art, if you will--that describes a great many particular programs. And the Professional Partner Program is one of perhaps other kinds of wraparound services. Professional Partner Program sort of had its initial beginnings in

1994 with a summit of discussion of how to do that in Nebraska. And in 1995, I believe, was the first year for funding of such services through the Division of Behavioral Health to regions, for that. The chart that is noted there identifies that Regions 1-4 were appropriated that specific amount. And we anticipate all four of those regions to have spent the money by the end of the fiscal year. The capacity was sort of the budgeted amount of additional people to be served, and the number served indicates that all of them have actually exceeded the expected number of persons and families to have been served in that area, which I think is certainly positive news. The next two regions decided--Regions 5 and 6, that is--decided to treat this opportunity in a little bit different fashion, and develop some pilot projects which took a little bit longer to get going but which I think are good examples of the different regions coming up and doing some different things. I know C.J. is coming up right after me so I'm not going to go into detail about that, simply to say that they are taking the best of the Professional Partner Program, experimenting and tinkering with it a little bit to help improve its effectiveness and responsiveness, and I think all of that is going well. At the bottom then, you see a couple of areas that I think are significant, and one is that this is known as an evidence-based practice. There can be a lot of controversy about EBPs or evidence-based practices because it depends on who's doing the evidence and who believes it, and that kind of thing. So there's just...there ought to be some healthy skepticism about some of that. Nevertheless, and notwithstanding that sort of academic or research kind of hesitancy, this has got some research behind it. And this is an area that is a solid area, I think, for funding, and has some numbers to support its interventions, and I think a good thing in that regard. I think this appropriation allowed for a flexible approach between the state and regions. And again, C.J. will be talking shortly about some of that flexibility and creativity that has gone into responsiveness here. And at this point, we're seeing quite a bit of family engagement and willingness to be partners in some sort of an intervention, though not in all cases. Some families say no in that case, and that's certainly their right to go to that. So I think that there have been a number of very positive things. I would note again that it's still pretty darn early to be able to give full sense of things, but the Division of Behavioral Health, along with

the regions, are tracking the LB603 services and money separately from its ordinary Professional Partner stuff. So we ought to be able to continue to report to you on numbers and on that kind of thing, over time. A couple of the concerns were that, of course, some of the smaller regions, as you can see, didn't receive very large amounts of money to be able to work with. I would again remind you that there is a formula that the division and regions have agreed upon for a distribution of funds that is based on population, and with a 25 percent emphasis on a poverty level or the poverty rate in that particular area--those with higher poverty rates get a little more money, kind of thing. So while it looks like not a lot of money, it's just the result of population issues. Some concerns with regard to the need for ongoing additional, more formal treatment services, more traditional kinds of treatment services, I think you heard much of that kind of discussion today with regard to things. And then, again, some families have chosen not to participate, and that will be the case. There may be a sense of "that's not what I was expecting; I wanted this over here," and so families continue to control their lives. Which, by the way, I think is a fine thing. So that's sort of a quick overview of some of the money, some of the services, and some of the numbers of people served. I'd be happy to either respond to questions or hang around and talk at a further time at your pleasure. []

SENATOR CAMPBELL: Questions that the senators might have? Scot, I have one question. As we looked at the budget for next year--of course, this was only a partial year, so we will go to the $1 million next year--will...and I'm sure C.J. might cover this but I just want to make sure I ask you so I don't forget. Will the pilot...the pilot projects will continue into next year? []

SCOT ADAMS: You know, at this point we're anticipating that those will continue. Because they're pilot projects, they have the ability to be tweaked and adapted, and that's the way it ought to be. You know, over time, there's still sort of a growing sense of what works, what doesn't work, how do we want to make this better--those kinds of things. But our expectation at this point is that the plans from Regions 5 and 6 have

indicated a willingness to move forward, and we're agreeing with that. []

SENATOR CAMPBELL: The second thing is, is that we talked in our meeting following that, a little bit about some future agendas. And one of the agendas that we will probably work on is hearing from representatives of family organizations, saying to an organization, you know, please send one person to kind of give testimony. So if you have family organizations that you work with--and we'll mention this certainly to the regions and all of us will be providing names--just send them over to our office to Claudia, because we'd like to make contact. []

SCOT ADAMS: Well, there's a number in the room today, of course, and... []

SENATOR CAMPBELL: Yes. And we'll announce that. But we thought that that might be one way to hear some information from the consumer or the families. []

SCOT ADAMS: Yes. I think that's a good idea. []

SENATOR CAMPBELL: So if you've got any groups, why, be sure to let us know--and an e-mail address would be great. []

SCOT ADAMS: Okay. Great. I'll make sure to do that. []

SENATOR CAMPBELL: Did you have a question, Senator? []

SENATOR COASH: I do. Thank you, Senator Campbell. Scot, maybe you covered this but I missed it. I'm looking at the...your chart here, that you sent me. And then in Regions 5 and 6, I'm looking at the number served. []

SCOT ADAMS: Yes. []

SENATOR COASH: Explain these numbers. I mean, how can you have a negative number? []

SCOT ADAMS: You know, actually that's... []

SENATOR COASH: How does this...? Explain how to read that. []

SCOT ADAMS: Thank you for...take the dash out of the way, and then so it...so, for in two quarters, LINCS has served 62 people. The Rapid Response program from Region 5 has served 11 in the first couple of quarters. []

SENATOR COASH: Okay. []

SCOT ADAMS: It really was just a matter of throwing it together and had those in there. So, you're right, it does look like it's in the minus. []

SENATOR COASH: So you didn't negatively serve someone? (Laugh) []

SCOT ADAMS: They did not negatively serve. We put more into the can...(laughter) []

SENATOR CAMPBELL: We didn't subtract people from the state (inaudible). []

SCOT ADAMS: Right. []

SENATOR AVERY: Is that X a Roman numeral for ten? []

SCOT ADAMS: You know, it is not. It was a Roman numeral for we didn't have the report in yet. []

SENATOR AVERY: Oh. []

SCOT ADAMS: But again, thank you for that question, because since that X was printed this morning, I have the information, and the service was offered to 24 families, and 11 of them have been served. []

SENATOR COASH: So the number would be 11. []

SCOT ADAMS: Yes. So the number would be 11. []

SENATOR COASH: Gotcha. Okay. []

SENATOR AVERY: A question, Senator. []

SENATOR CAMPBELL: Oh, sorry. Senator Avery. []

SENATOR AVERY: You note here, under "Cons," services are voluntary and that there are "still some families requesting services that may not be appropriate or available." Give me an example of some programs that are not available and that are being requested, and some requests that are inappropriate and how that's determined. []

SCOT ADAMS: Well, you know, being on the recent side of having raised four kids and still having a couple at home, my experience with behavioral health was that that was traditionally understood as sort of an inpatient, hospital-based kind of treatment approach. And for a lot of folks, I think there's an expectation that a hospital or a residential treatment program is the best way to go and the only way to go, perhaps. And so, wherein a program like a Professional Partner Program comes along, it certainly doesn't start off with a residential level of care. And so, by that, is there's just a mix of expectations of what can help a family to get better. With regard to...and so that's an example of what I would describe as the not necessarily appropriate. []

SENATOR AVERY: So this would be a family requesting... []

SCOT ADAMS: Inpatient care. []

SENATOR AVERY: ...inpatient, but... []

SCOT ADAMS: Yes. And the Partners... []

SENATOR AVERY: ...somebody makes the determination in...where is that? []

SCOT ADAMS: The determination would be in discussion between the Professional Partner Program, with the family, during the assessment phase. It may also include Magellan at some point. But it doesn't necessarily, actually, have to do that, because Professional Partners would be authorized and they would go from there in that regard. And, you know, with regard to the "not available" service, I don't know that one off the top of my head. That might have been just a typing kind of thing. Let me get back to you on that and see if there was, in fact, specific examples of that kind of thing. I would also note, though, at this time, sir, that one of the questions...there's another component, of course, to the LB603 element in these services in here: evaluation of the Hotline and the Family Navigator component. And the evaluation, which is being done by a group called Hornby Zeller, is looking at exactly that particular question. And so with greater detail and precision, that will be measured and reported back to you as that data becomes more available. []

SENATOR AVERY: Thank you. []

SENATOR CAMPBELL: Any other follow-up questions? Thank you, Scot, very much. []

SCOT ADAMS: Thank you. Appreciate it. []

SENATOR CAMPBELL: Okay, C.J., before you start...go ahead and sit down. Please just sit down. I know that some people are on different schedules this afternoon and may have to leave, and I want to make a couple of announcements in the sense that we probably will have several more meetings over the summer. We'll try...if you are not on the e-mail list, you may want to put your e-mail and give it to Claudia. And also to introduce Claudia Lindley who is on the far left here, who is my legislative aide, who is serving today as the clerk for us. And if you want a few chuckles, you can hear about Claudia's experiences. Over the noonhour we heard some experiences. This job is harder than you think it is, is what the chuckles are caused by. But, in any case, we want to keep you apprised of the schedules as we go along, so make sure that Claudia has that. And I also want to say one other thing, because we've had an inquiry over the noonhour, about television. We've been in discussion with the Legislative Council, and most of the time what is televised are public hearings in which testimony is being taken and someone is always talking from that chair. When we do kind of hearings like this and they're not really a hearing but a discussion back and forth between the committee, they will not be televised at this point. But once we get to the point where we are taking public testimony in a hearing situation, then they will be. So thanks C.J. Thanks for letting me make those housekeeping things. Welcome. []

C.J. JOHNSON: (Exhibit 5) Welcome. I'm very happy to be here, and I want to thank you for inviting me. I am speaking on behalf of all of the regions in relation to the use of the LB603 dollars. However, I will acknowledge that I'll probably spend a little more time talking specifically about what is going on in Region 5, simply because I know that the best. The packets that you have before you are just...are supplemental information for the six regions, provided additional data in relation to LB603. I will be sharing some of that. And also I took the liberty of including some reports that I had generated last year when the safe haven bills were being introduced in relation to, oh, cost comparisons and a variety of some other things, which I may also get into, but if not, I did provide those pieces of information. The other thing I would like to say is that if my numbers and Scot's numbers don't always...aren't always exact, that could easily depend on when we

put together the report, because especially on some of the emergency numbers, we could make the difference between six or seven referrals, so I just wanted to also point that out. But I did look over the numbers and they're very close. So okay. In relation to the Professional Partner Programs, Scot provided a brief history. A couple other pieces that I want to share about the Professional Partner Programs and the wraparound process, two other integral parts to that program is--and this is integral to the wraparound process itself--is the use of flex funds. Professional Partner Programs set aside, as part of the overall rate that they receive and/or funding they receive, a pool of money which we call flex funds. It was found out during the 1980s and '90s when they were really looking at wraparound, that one of the things that many times happened was when a team was put together with the facilitator and the formal supports or the informal supports, many times either the family or a member of the team required some additional support which wasn't readily available, say, through a Medicaid forum or a traditional service. An example might be, you might have a teacher on the wraparound team who, if he or she received specialized training, would find it easier to work with the child in a classroom setting. Well, maybe the school wouldn't have funding for that or maybe there wasn't some other funding resource. So those flex funds could be used to actually pay for a teacher to go to a special class. There's a lot...a wide variety of uses of those flex funds, but that is an integral part of the wraparound process itself. And then, although it may not be unique to Nebraska, all the Professional Partner Programs have a relationship with the family organizations in their particular regions. In Region 5, for example, Region 5's Professional Partner Program has contracts with both Healthy Families Projects and Families Inspiring Families. Both Healthy Families Project and Families Inspiring Families provide parent partner support to those families. Again, parent partners are parents who they themselves have dealt with the system because they had a child who had a serious emotional disturbance of some kind. They've experienced that. And many times, then by connecting them with a family member involved in the Professional Partner Programs, it really helps that parent feel supported and feel like they have an advocate right there. A lot of times it can be very intimidating when you're going into a team of individuals or dealing with a formal system such as a

school system or something. The other piece with our contract with Families Inspiring Families is they do our evaluations for us. In other words, they call the families and take the information on the various evaluation tools that we use. That way we know a family member is talking to another impartial person. Our reports we get back we feel are very objective, and so, therefore, we can have a good evaluation of the program. And similar relationships are like that with all the other Professional Partner Programs. As Scot said, Regions 1-4, because of the amount of funding they received, specifically expanded their current what we're calling now a traditional Professional Partner Program. And the reason I say that is, over the years, when various funding streams have come in, different Professional Partner Programs have tried different things. For example, school-based Professional Partners, whether the Professional Partner is specifically assigned to a school or a set of schools, and that school works with that Professional Partner for identified youth. Region 3 has ran a pilot program for a period of time that was specifically designed to deal with children under the age of 5. That was an early intervention program. Several of the regions, over the last year or so, have targeted transition-age youth, 18-25. We were finding, in our region, that 25 percent of all our emergency protective custody holds were youth between the ages of 18 and 25, but they didn't represent near that much in the population. Since then, we've seen a significant decrease, not only in our repeat admissions, which were significantly those age of youth, but we also have continued to see a decline in our emergency protective custody holds for that age group. With the LB603 money, I'll go to Region 6 first. They did two things with their funding. The first one was they recognized that their infrastructure that they had did not have a crisis response, specifically to law enforcement. Many times, when a family is encountering a behavioral issue with their child and that child is out of control or those parents feel afraid for some reason or they don't know what to do, a lot of times they call law enforcement. And law enforcement, historically, have been challenged in relation to what to actually do with those youth. I know through my conversations with law enforcement, a lot of time they simply...they either have to just leave and hope everybody stays calm after they've left, or they end up transporting youth to a psychiatric hospital for an evaluation. In Region 6, they've

developed a mobile crisis team. It is available specifically to law enforcement when they're in that kind of situation. It has professionals that go out and meet with them. It's in a collaboration with Lutheran Family Services. They started that program January 4, 2010. They've had ten referral calls since then. And so that program is just up and going. In Region 5, I'll speak to a similar program in Region 5. Region 5 already had that crisis response program, as well as several of the other regions. We've embedded that in our crisis response teams that was established with behavioral health reform that was passed in 2004. And again, it's when law enforcement is encountering the situation I described. They call an 800 number, and we send out a therapist and, many times, an emergency community support worker to work with that officer or the family and the child to look for an alternative for that family. The second thing that Region 6 did with the LB603 money was to create what they're calling a Rapid Response Professional Partner Program, which is part of the traditional...or a subpart of the Professional Partner Program. It's a 90-day focused program. It is based on referrals that they receive, and it's to provide intensive case management services over that 90-day period. The Professional Partner will meet with the family and the team, one to two times a week during that period of time, to try and help that family identify...do an assessment, identify resources, and then try and help build those supports for those families. At the end of 90 days, then the Professional Partner and the family might make a recommendation. That could be that they move into the traditional Professional Partner Program. It could mean that the family is feeling comfortable enough with the support services that they've received and the support they've received that they feel they can just continue on without any other formal kind of intervention or support that way. And I believe, to date--and let me just, quick, check--in that particular program, they have received 49 referrals, and of those 49 referrals that they've received, 19 individuals have been admitted into that program. I'll move on to Region 5 now. As the safe haven bills were being discussed, I was approached by Lancaster County Human Services Department to ask if we could possibly help them. And what was going on at the time was their county attorney was receiving a number of calls from families seeking to make their child a state ward for the various reasons we all know from the safe haven

activity, and wanted to see if we might be able to help. Well, at the same time we were anticipating that there might be some funding in relation to this, and it made sense that based on the reason for the LB603 money, we specifically sat down with the Lancaster County Attorney and began to talk about what was going on. And at the time, when the county attorney was getting called, they were generally hesitant to want to file that file to make that child a state ward. So they have reached an agreement with Child Guidance Center to do an assessment for those families. The Child Guidance Center was doing that with no payment. They were...and that's not a good thing; they were just trying to help out. And part of the reason they were helping out was because we were funding a position for the youth detention center in Lancaster County, and so they were already kind of a part of that system. What we determined we would do once we did find out we have the LB603 money, the $121,000, is, first of all, develop what we're calling a Prevention Professional Partner position. We also began to work, continued to work with the county attorney, the Youth Assessment Center in Lancaster County, and Child Guidance. We provided funding to hire a full-time therapist who is available to do those assessments that the county attorney...when the county attorney gets called. We expanded the referral source to all the counties in Region 5--so it's 16 counties. We also began to approach other sources, such as the juvenile probation, the Lincoln Public Schools SMART Teams who look for youth that are at high risk. And since we started this system, which we're calling LINCS, which means Lincoln Individual/Families to Community Supports and Services, we've had 97 referrals. Of those 97 referrals--let me just go to my quick sheet. I knew them until I told you Region 6's. Of those 97 referrals, 28 of those families chose not to follow through with the assessment. Twenty-four family and youth assessments were completed. Eighteen of those families were referred to other community services and not requiring additional formal support other than what was available in the community. Six of those youth did become state wards. I should point out that two of those youth were already involved in the juvenile justice system; had committed some offenses. Two of the other youth--the parents, after hearing what was offered and what the assessments were, still felt that they would need to seek state wardship to get the services they felt their child needed, and so they proceeded on. One

other youth was...due to truancy, was made a state ward. So, in total, out of the 97 referrals that we received, 91 of those families did not continue to seek to try and make their child a state ward. And I'll kind of talk about the impact of that, and I think Senator Avery, especially, you're always talking about the money side of it, so. The number of referrals that we did receive in the Prevention Professional Partner Program was 28, and the number of youth that were actually involved in the program has been 17 at this time. So with that, are there any questions at this time, and then maybe I can run through some other number issues. []

SENATOR CAMPBELL: Any questions? Senator Avery. []

SENATOR AVERY: I'm curious about the families that declined services, don't follow through after assessments. Do you have any information as to what causes someone to recognize they need help, then decline that help when it's offered? []

C.J. JOHNSON: Well, I should let you know I'm also a licensed clinical social worker and a licensed marriage and family therapist, and have been practicing for 20-some years in the field. And the reason I bring that up is I can tell you numerous times where I've had families call me, just feeling totally frustrated, you know, with what's going on, or they felt like their child needed therapy. And you set up an appointment with them, okay? And then they call you back a week later or so, and say, you know what? We've been talking this over and we've been looking at the situation; we feel like we can probably keep trying some other things. Or a lot of times just that contact alone, kids might start doing better. It seems odd but it happens, and that's been my experience over all these years, that a lot of times just reaching out to that level is enough to kind of fortify a family to say, you know, we can probably continue on with this, you know? And the other side of that could very well be that other professionals that are working with the families are getting frustrated, and not so much that the families are that frustrated, but the professionals are, and are saying to those families, you need to go make your child a state ward. And so they're calling the county attorney or calling these

individuals--and when they finally call, at the same time they say, no, we're not going to do this. So I rarely would say it's just because families don't care and they don't want help. It's those kind of circumstances that I think, once they've made that call, would cause them to reconsider. []

SENATOR AVERY: Is there a certain level of, oh, shocking families into a reality check when you get to the (inaudible)? []

C.J. JOHNSON: A certain level? []

SENATOR AVERY: Yeah. []

C.J. JOHNSON: Well...I...you know, I don't...when we talk about the reality check, I think because they're calling, they know they're struggling, you know? I think one of the things that...we need to be...I wasn't going to liken it to this because it's so dramatic right now, but I just have to--you know, what's going on in the Gulf. It's kind of what happens for families, you know? Those people down in the Gulf, they knew how to drill. They knew how to do this stuff; that's what they know how to do. But when something happens like suddenly their child develops a mental illness or suddenly their child has a...they find out their child has a learning disability, or suddenly some trauma happens within the family--you know, most of us are ordinary people. I mean, I don't know how many people in this room have gone through schooling and training to learn how to diagnose and do treatment and behavioral health interventions, but I would guess not very many in this room, but yet we've all tried to be parents--or most of us have. And so when that happens, you know, all of sudden, we...the perspective is that these parents should suddenly become behavioral health experts as well. And they're not. But they try. And that's...and I liken that to, you know, parents will try. A lot of times, what they're trying may be ineffective--but they're trying. And rarely...rarely, over all the years that I've worked with families, have I ever encountered a parent or a family member that doesn't care, isn't interested, doesn't want to help. They just don't know how. They just

honestly don't know how. And then they start--and then again, the Gulf thing--then they start asking for advice. And they're getting advice from neighbors and friends and people they don't even want advice from...and, you know? So now they have all these different perspectives on what they should be doing with their child. It can be very confusing. And then to try and access the services and adjust those. So I think there's just a point, you know, where families just don't...they just don't know which direction to go and what to do. And amongst all that, you know, the kids start feeling anxious because they need that guidance, but they're not getting it. And they start feeling anxious; they start acting out. There's just a lot of stuff going on there, so. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. Thank you, C.J. I'm just so excited to see that each of the regions are using this money in a way that fits their region. And I think all too often we try to make a one-size-fits-all approach to problems, and our state is very diverse and has a lot, so I'm very pleased to see that the regions are recognizing what they need to do and are using that money appropriately. On several of the regions, I think there's been some helplines or some phones calls. So I guess I would like to get your viewpoint on, you know, we have the statewide 24-hour Hotline. Do you see what's going on in the various regions complementing that Hotline? How do you see that Hotline benefitting what the regions are doing?--our statewide Hotline. []

C.J. JOHNSON: Well, two things. One is, I do believe that the data we're going to get from the Helpline should help us determine what level of services may not actually be out there, or...and it may not be services; it just may be what kind of supports aren't out there. When you look at a lot of support recommendations from the research, a lot of times in relation to families, it's not, you know, an LMHP or an LCSW or a psychiatrist or a psychologist that's going to come in and save the day. A lot of times it's having an active parent support group or it's having an active parenting class that is on a regular basis and available to individuals. There's other kinds of support networking that we

might find is actually what these families are needing. And a lot of times it's not a big money deal, you know? It's just a coordinating deal. So that's the one thing. The other thing that we've started doing is in relation to those families who do contact and are referred to the Family Navigators. Because the Family Navigators is kind of a time-limited intervention, one of the things that we've also done is worked with them in order to take referrals at that point. When they think, oh, you know what, this could be really good if they were with a traditional Professional Partner Program or if they were maybe supported with the prevention program. So we've worked that out. And as of...in fact, Region 5 started that June 1 and have already had four referrals as a result of that, so. So I think they complement each other is what I'm saying. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: And I think that was surely the intent, at least from the description to the Health and Human SErvices Committee early on, was...didn't see it as a long service, but if they then needed that parent support, we could do that. So out of the numbers--I just want to make sure I have this right--so of those families that did not have to become a state ward, that would have been, what, 18 families? []

C.J. JOHNSON: For which? []

SENATOR CAMPBELL: In the LINCS program. []

C.J. JOHNSON: Oh, no--91 out of 97 referrals. []

SENATOR CAMPBELL: Ninety-one. Okay, I must be reading the wrong chart there then--oh, there we go. Thanks. []

C.J. JOHNSON: And let me just share with you what the economic impact is of that in relation to the state of Nebraska. Last year, I...because the regions had been operating

the ICCUs, we were very intimate with the case management costs associated to the state in relation to that. And these figures are from last year so they might be slightly different, but probably not much, is at the time that I looked at what the case management costs were to the state of Nebraska for a child that has become a state ward, the average length of stay for those children was about 20 months. And just in case management costs alone that was right around $44,000. At the same time, if you looked at the Professional Partner Program and looked at the average length of stay, that was right around 16 months across the state, and the average cost for that was about a little over $12,000. So about a $32,000 difference just depending on which program that involved. Now I'm going to make an assumption that 97 of these families were being directed to make their child a state ward in some capacity. If 91 of them didn't, that's a cost savings to the state right there, you know, of almost, what, $3 million, $4 million, you know, having not made their child a state ward. So $121,000 was invested and, already this year, if we made that assumption, you've already seen a $3 million savings to the state just in Region 5, okay? And I want to point out, you know, a lot of people might say that the Professional Partner Programs cherry-pick the kids maybe--you know, that old argument. Well I also looked at the CAFAS scores last year, and CAFAS is the Child and Adolescent Functional Assessment Scale, and the higher the number, the more likely it is that a child needs maybe residential care or multiple interventions. The average CAFAS scores for those youth in the Professional Partner Programs at that time was 108. The average CAFAS score for youth that were involved in OJS as state wards was 82. So even the youth that were involved in OJS, who had actually committed some kind of offense or status offense and were involved in the court system in state wards, had a significantly lower CAFAS score, meaning that they needed significantly less support services than those children who were still living in their home but their parents were seeking additional support. I also should point out that the Professional Partner Programs at that time saw a 44 point change in that CAFAS score from the time they started to when they were discharged from the Professional Partner Program, and in the OJS system there was a 22 percent change, okay? So there's not cherry-picking going on. In fact, of the 97 youth that were referred, their

CAFAS score average was 106, so they're still extremely high-needs youth. These are youth that just outpatient services isn't going help, and, in fact, they need probably something higher than outpatient services, and many times they need multiple types of services at one time, so. Any other questions? []

SENATOR CAMPBELL: Senator Avery, go right ahead. []

SENATOR AVERY: I'm curious about this assessment scale. How reliable is this? []

C.J. JOHNSON: Oh, the CAFAS scale was developed by Ann Hobbs many, many years ago. It has passed reliability tests time and time again. Anybody that does a CAFAS score, all are ran through a training packet. They have to submit that training...they have to do their own CAFASes based on all that experimental piece around reliability, and send that in, so anybody doing a CAFAS is certified to do that nationally. It's nationally recognized as the quality assessment scale in relation to a child's risk. []

SENATOR AVERY: So a child that scores of 100 on this scale, you can be fairly certain that you have an accurate measure of that child's needs. At least you know their level of need. []

C.J. JOHNSON: Their level of need, yes. []

SENATOR AVERY: You don't know specific needs,... []

C.J. JOHNSON: Right, you wouldn't know specific needs. []

SENATOR AVERY: ...but you know that they need intensive care. []

C.J. JOHNSON: Yeah. It would tell you... []

SENATOR AVERY: And it's reliable in that. []

C.J. JOHNSON: Yeah. []

SENATOR AVERY: Sounds very useful. []

C.J. JOHNSON: It is. And, you know, there are a number of other scales out there that are equally reliable that are used, either by the state and/or the Professional Partner Programs or both use those scales, too, so you can kind of cross compare like I just did in relation to, oh, those kind of issues related to youth. []

SENATOR CAMPBELL: Senator Coash. []

SENATOR COASH: Thank you, Senator Campbell. C.J., I want to talk about or ask you about the, just kind of--and you can just speak to your region specifically--but I just want to talk about capacity and, you know, we know how many families you served. What's your sense of families that aren't getting served that could be? I mean, you're limited with the resources we allocated. You know, what you're talking about is how many...the cost savings and keeping kids from becoming state wards is enormous, and the more that we can use our resources to keep kids out of the state's care, the better we are. So I guess I'm asking what your sense is of, you know, what's...are we meeting...are you getting enough funding to meet the needs of your region? Or are there families that you're having to...you know, are you turning down families because of limited resources? []

C.J. JOHNSON: Well, we have consistently maintained a waiting pool, and the reason I call it a waiting pool is when a family calls in, we go out and do a screening and we get a ranking or a rating of how high of risk that child is of being removed from their home or school or community at that time. And at any given time that we have an opening, we look at that level of risk versus, oh, they called first, therefore. Now what I do want to

clarify is while a family is waiting, if you will, we're making other referrals for them; we're checking in with them to make sure how are they doing. We may reassess that risk at any given time. With that said, we consistently have anywhere from 20-30 families sitting in our waiting pool. So, right there, I can say the need is not being met. And I can say that...not only did we expand using the LB603 money for that triple...the prevention, but we also added two additional of those type of positions with some other funding. And we still have this waiting list, you know. So I would...we're not meeting their needs...we're not meeting the needs of the families out there was far as numbers available. []

SENATOR COASH: So you're...you've got approximately 30 families that have requested services you haven't been able to, so your process is when you have an opening you look at those families, and then based on...you don't...you choose to serve that family based on their level of risk, not how long they've been waiting. []

C.J. JOHNSON: Right. []

SENATOR COASH: So you try to help the highest-need families first. What...if you're in that...if a family is in that high-risk need category, how long are they typically waiting for you to call to say, okay, now we can now serve your family? I mean, what...so we know how many are families are waiting. Do you have a sense of how long they're waiting for services? []

C.J. JOHNSON: Those youth that are extremely high risk, it may be about 30 days before we can actually get them enrolled, if they're extremely high risk. And I...and because I also provide the clinical supervision of that program, you know, we might assess that with a youth. We just...or sometimes we take a look and say, you know, you have a family that's probably going to discharge 30 days from now. Can you go ahead and pick this family up now, you know, knowing that you're going to have a higher caseload than you need, for about a month or so? And a lot of times we accommodate

the real high-risk families that way. []

SENATOR COASH: So the...well, let's say I'm a...go to the other end, like a family whose risk isn't that high but can still benefit from services, and my sense is that the risk may not be high initially, but without services that risk could get high,... []

C.J. JOHNSON: It might. []

SENATOR COASH: ...you know, without services. So if you're on that lower end of risk, how long, typically, is that family waiting? Because I'm thinking that maybe those guys are waiting forever because you're prioritizing the high-risk families. []

C.J. JOHNSON: They might. And so a lot of times what we do is, at this point is if we see a family that, you know, we see that child is probably never going to reach that level of risk, is just they're going to be sitting there, what we'll do is, like I said, we'll look for other support pieces. For example, with our contracts with Families Inspiring Families, we'll ask them, hey, could you assign a parent partner to work with this family? You know, they're still involved in our program; could you go out and...? And a lot of times that's adequate enough for the parents to feel that they're getting the support they need to then support their child in relation to services. You know...and I want to go back. A lot of times it's not about the lack of services. I want to point that out. Sometimes it's just about the lack of coordinating all the stuff a child might need. I mean, just imagine if you had a child who, you know, had to go to therapy and you had IEP meetings and you had to deal with the school on a regular basis, and you've got...I mean, a lot of times...and a lot of times that's just because it's...the wraparound process coordinates all those people towards common goals and provides the resources for them. And that's why that can be so effective sometimes without higher level programs, because a lot of times it's not a matter of lack of; it's a matter of just how do you coordinate all that. And that's what a Professional Partner does. They help the team move their energy in a similar direction rather than going all over the place. []

SENATOR COASH: Thank you. []

SENATOR CAMPBELL: They serve as like the case manager for that. []

C.J. JOHNSON: Yeah, it's...it's more than...even though all the regions are accredited as intensive case management, that's kind of a...when you think of case management, you're...you know, it's that whole management case. Professional Partners really just facilitate the team and don't manage people per se. You know, they bring everybody together and say, okay, what do we need to do as a team here; what resources do we need? And many times, for a team, they may just be a broker, if you will, you know, where they're trying to help people access services or other supports or whatever, so. Even...I know we use that word because that's...it gets to interchanged and everything, but. []

SENATOR CAMPBELL: But the broker is probably the best word for it, because it's...you're arranging... []

SENATOR COASH: Facilitator. []

SENATOR CAMPBELL: ...their schedules or those services. []

C.J. JOHNSON: Yeah. []

SENATOR CAMPBELL: Exactly. So you're saying and looking at the families that you might deal with, it's not necessarily always a lack of the service. []

C.J. JOHNSON: Right. A lot of times it's just not knowing or not knowing where to go or...it might just be overwhelming trying to coordinate it all. And, you know, quite honestly, I...like I said, I do clinical supervision weekly, and sometimes, you know,

professionals disagree, too, and then the family is trying to decide which professional to listen to. And so a lot of times, you know, I'll hear something and I'll go, well, that doesn't sound like that to me. And I want to point out that's not saying professionals aren't professional. What people need to understand, in general, is that diagnosing a behavioral health condition of some kind with a child is very difficult a lot of times. When I say a child, 18 on down, most kids--and when I say kids: 18 on down--can't articulate their symptoms. You know, they act them out because they can't describe it or they don't understand it. And then if you do start a medication on a child, they can't articulate how that's making them feel. They just act it out. And the problem is when you act something out, everything looks the same. So you could have three children with three totally distinct, different mental health conditions, and you could watch them all for whatever period of time you want and they all look they're the same thing, and you're like, well, two of those people got to be wrong. Well, they're not. It's just that, you know, a child can be irritable, whether if they have a bipolar condition or they have an ADHD condition or if, you know, they have an anxiety condition, they all could look just irritable and act just the same. So it's very challenging, in working with children anyway, to make diagnoses, a lot of times, and so sometimes you do get two professionals making a little different assumptions about what's going on, so. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: Thank you, Senator Campbell. You mentioned earlier, they used the word flex dollars, flex funding. Do you consider this money that's in Professional Partners or that's coming into the region, do you consider those flex dollars? []

C.J. JOHNSON: Well, the way we do that is we had a number of years determining kind of what a case rate would be in relation to carrying out this. And so, with that case rate, we chop off a certain percentage of that case rate and say that's going to be used for our flex dollars towards our families, okay? And that's...with the LB603 money, even though it came as kind of a lump, we first carved out what we needed for the therapists.

The rest of it funded an additional...the Prevention Professional Partner. So what we would do is go in. Okay, a certain percentage of that is being set aside as flex funds for the families they're working with is how we do it. So not all the dollars, "oh, that's all flex funds now"--we don't do it that way. []

SENATOR DUBAS: Okay. All right. Well, then when you were talking about what you are assuming the savings to be with those children who do not end up being state wards, is there a way for us to quantify those savings? I mean I think that would be huge for us to know, as policymakers. []

C.J. JOHNSON: The challenges...anything we do in prevention work, that's one of the hardest challenges. Now I do know that if we look at, like, CAFAS scores and know that those children entering have significantly higher CAFAS scores, if we look at...if we could find out--but county attorneys aren't very good at keeping records on things--if we knew exactly how many times a county attorney was contacted to make their child a state ward and what percentage of those they actually followed through...so, let's say it was 30 percent, okay? Well, I could go back at the number of referrals we got done, okay, and say of those 97, if it was 30 percent...okay, that means 30 of those youth would have been state wards--and only 6 were--so that means 24 did not become state wards as they had in the past. So I could...you could make some assumptions that way, okay? That's kind of...it's like the emergency protective custody. I mean, when we introduced our crisis response teams, we literally saw a 50 percent reduction in rural EPCs, you know, and you can put money to those. But at the same time, people might say, well, maybe...yeah, maybe you're not really preventing something because maybe you just aren't having that many contacts as you used to. And you don't know because law enforcement doesn't keep track of that, you know, so it's challenging. But I think you can make some very good assumptions in relation to trying to find out those kind of things and then move forward with it. []

SENATOR DUBAS: Is there a way that we can actually capture those dollars so that we

can put them into places where they're going to...that we can kind of turn them into a savings account where we're going to...? []

C.J. JOHNSON: Well, you would think so, and if I seem a little smug at this point it's because I am being smug (laughter), because a number of years ago when the ICCUs were developed, they were specifically developed where they took only the service dollar costs, those kids that had the highest service dollar costs, okay? They took that money, looked at that, and they took 5 percent off the top of that. Now that didn't count case management costs; that didn't count...and they gave them to the regions. Started out at Region 3 because they had a system of care grant to start that. And so for 95 percent of just the service costs, they said you basically do what we've been doing. And if you realize any cost savings, okay?--you can invest that in additional behavioral health services, okay?--but before you can do that, as you're saving money, we're going to start up other ICCUs across the state. Well, just a couple years ago those cost savings were in the amount of about $6.2 million, okay. So I think you can...you should be able to shift it because if you have less youth involved in child welfare, you need less case managers and you don't need as many services, so there should be able to be a shift that way, I would think, you know. Because they are...it's already been demonstrated that you can do that. []

SENATOR DUBAS: You know, not just in this area but in so many areas, when we get reports as senators, and it's like, okay, this shows a savings of X, but yet we never really see those. We can't put our hands on those savings. And so I guess what I'm wondering is if we really are seeing these types of results? And rather than assuming, is there a way that we can quantify those savings, and is there a way we can take those actual dollars and put them so that you're able to serve these 20-30 families in a quicker fashion? []

C.J. JOHNSON: I think there are. I mean I think there are because we've already demonstrated it, that it can be done. The challenge, though, and I will say this as that it

would have to be clear that--and it doesn't have to be all the cost savings--but it has to be clear that those cost savings will be utilized to do that. One of the things that has happened over, you know, what I'd say is the last six years, is any time any cost savings has occurred in that way, and a risk pool gets developed, if you will, to invest it, then a decision is made that you need to use your risk pool to pay for your program until you use it all up, and then we'll start letting you draw down your money again. So you can't invest it out there. You're kind of investing it here, which then filters back, and actually at the state level, makes it look like, gee, we had a cost savings, you know, when that wasn't where it really occurred; it actually occurred out here. []

SENATOR DUBAS: So we could use those dollars as an incentive for people who are in administrative positions, such as you, to say, okay, if you can make these programs be successful; if you can actually reap savings, reap benefits, we'll let you use those dollars to...which, in turn, if it worked the way it's supposed to, would require less dollars from the state because you are keeping those dollars internal, and you're churning them over and using them. []

C.J. JOHNSON: And when I say internal, they're not within the region, but like additional services or whatever. Yeah. []

SENATOR DUBAS: Correct; correct. []

C.J. JOHNSON: Yeah...or, you know...and I know you and I had had this conversation last year. It's really about, you know, do you build a fence around the cliff or do you fund the ambulance at the bottom of it, you know? And it's a lot cheaper to fund a fence, you know, but a lot of people like the bells and whistles of the ambulance, and so. But if we could just really look at programs that kept people from going into higher levels of care and help support them in those lower cost levels of care, that would be the way to really invest a lot of money and help a lot of people and still recognize cost savings. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: Senator Avery. []

SENATOR AVERY: Let me follow up on that. Isn't the biggest obstacle doing what you just said? And I agree with you, the biggest obstacle, it seems to me, is that we have a hard time looking into the future and saying, all right, what we do now, which might cost a little bit more, will save us money in the long term. We don't look to the long term in government; I mean, we look at now. And if it's going to cost a nickel more now and save us 25 cents later, we're going to save that nickel now and spend that 25 cents later. We do it all the time, and that means we lurch from crisis to crisis and never do any long-term planning, although we're trying to do that in the Legislature now. []

SENATOR CAMPBELL: Any other questions or comments? C.J., I've just been trying to leaf through the report, and we will take some time, obviously, to read all that you've given us. Is there any particular section that you might not have covered today that you say, please pay attention to this because I didn't get it covered as thoroughly as I'd wanted it to? []

C.J. JOHNSON: You know, I don't think so. I mean, you know, to read about the specific data, you know, that each of the regions are seeing that provided that. But I really think that...oh, the other thing I guess I should say is when the bills were being discussed, I did project out that for every million dollars of investment into, like, the Professional Partner Programs, this is how many families would be served. And, right now, 72 families have been served. For a million dollars' investment, which will be this next year, that was around 142 families that would be served in that. So I just want to point out it's right on target that way. As far as the cost savings, there is a piece in there that makes some assumptions, and part of that qualify. One of the things we know is, in the Professional Partner Program sometimes youth do become state wards, okay? We know that. So I even made...I made some assumptions that what if we weren't doing as

well as we were and X number of youth were being made state wards?--this is what the potential costs would be to the state. So there are some other comparisons in there that you might want to take a look at. I think it's consistent. I think of all the long-term interventions, investing in preventing children, number one, from ending up in the child welfare system, which nobody wants anyway, is a huge investment in a long-term cost savings to the state. And secondly, it's a huge investment in long-term cost savings to the state if we help these families and children get to the point where, when they get to adulthood, they're not going into that system, you know? And I know there are families right in this room, right now, that can probably tell you there was a point in time where they couldn't have imagined their child not ending up in that adult system, and I know there are some families in here who can tell you their children did not end up in that adult system because of the support they got, especially from the wraparound process, you know. And, in fact, there are those children who have gone on to successful careers, graduated from college, etcetera, which I would bet at one point their parents never even could have imagined, so. []

SENATOR CAMPBELL: Senator Dubas. []

SENATOR DUBAS: You've (inaudible) another question for me. Senator Campbell definitely touch on this, this morning, and, you know, we have the child welfare system and we have the children's behavioral health...you know, we've got two very distinct, but yet they shouldn't be that distinct, should they? I mean, is there a lot of blurring of services that are provided for children out of both of those? []

C.J. JOHNSON: Yes. Yes. And I can comment on that if you want. []

SENATOR DUBAS: Please do. []

C.J. JOHNSON: And I've talked to Senator Campbell about this, and I know I have you, as well, Senator Dubas. You know, if you were to go to my lawn, you know, it's pretty

well landscaped, got a lot of plants and stuff like that, but, you know, what? I could not walk through there and tell you those plants individually, but I could walk through and say these are the trees, these are the crap, those bill elephant ear plants--and now I can't remember them. Hibiscus? No. Is that what they're...? Whatever they are. []

SENATOR CAMPBELL: Hostas. []

C.J. JOHNSON: Hostas. Thank you. []

SENATOR CAMPBELL: A little help there. []

C.J. JOHNSON: And these are the holly kind of bushes, you know, and they are...I could do that, you know, and you would be somewhat impressed by my ability to do that. But what would be more impressive is if I could tell you that for the hostas, they need shade and they need a certain amount of water--the intervention here--and you can't use Roundup on any of these but you can use that Weed-B-Gon stuff on the grass. I mean, that's pretty impressive. And the reason is, is because I've clustered those plants, if you will, into specific groups that have similar histories, for lack of a better word. They don't have the same diagnoses, but they have similar histories. Well, there is a process out there called cluster-based planning, both for adults and children, which really allow you to go into any segment of a children's population and make a very quick and simple assessment, which says this group of children are more like each other than this group, and this group of children are more like, you know, each other than this group. And it's not based on diagnosis. It's really based on their history, their experiences, and stuff like that. And the reason that's important is because if you want to start looking at outcomes and treatment interventions and support interventions, it's much better to look at how those interventions or how those are being done with those kind of groupings versus trying to go out and say, let's get all the children who have a bipolar condition and let's look at outcomes. That's not a good way to do it--because it's the history. You know, if a child has experienced trauma, those children are going to

look more alike, you know, despite what their diagnoses are. So then you can start making some assumptions. If in our system we have 10 percent who fit in this group and they need these kind of services, then maybe we should invest, quote, 10 percent of our funding or whatever that is towards that group, so we're not having too many, you know. And the same thing with this group. If this group needs more of this kind of stuff, we can invest our funding over here towards those kind of supports. And then you can also look at their outcomes based on, you know, it could be based on interventions or agencies or regionally, maybe. I mean there's all kinds of ways to start looking at that group, much easier. And, quite honestly, it's a...you can make that determination on a child and/or an adult in a normal assessment conversation, and it's a one check on a box that can go in a data system, and you could, in a very short amount of time, start telling what those groups are. And there's already research out there that has identified those groups, created that tool, has the training available--and I already did my little speech. []

SENATOR DUBAS: Thank you. []

SENATOR CAMPBELL: Thank you. []

C.J. JOHNSON: And I'm sure people are getting tired of cluster-based planning, but...and I should let you know Region 5 did invest, not LB603 funds, but a variety of funds to actually bring in somebody from Ohio that does that kind of training. We invited people from all over the state. And we are now looking at beginning that process of training direct line people specifically on how to do that--that assessment--at least in Region 5, so. []

SENATOR CAMPBELL: And so I'm assuming--I'll ask you the same question--that the pilots that have been started will be continued in the next year so that we have more data to look at. []

C.J. JOHNSON: Absolutely. []

SENATOR CAMPBELL: Good. Excellent. Any other questions? Thank you very much, C.J. []

C.J. JOHNSON: Thank you. []

SENATOR CAMPBELL: We appreciate it and would certainly hope that you convey to all the regions that as they have information they'd like to share, we'd be delighted to hear from the. []

C.J. JOHNSON: Absolutely. []

SENATOR CAMPBELL: And he did pretty darn good on that nursery analogy. (Laughter) Okay. I have no other items for the agenda. []

SENATOR COASH: (Inaudible) announce about the families. []

SENATOR CAMPBELL: Oh, yes. One of the things that we do want to encourage is we are planning a session or we will plan a session to hear from different family groups in the state, and I think you heard me ask Scot to forward to us some names. If you are here representing a family group today, we would hope that you would begin thinking about a representative from your group that may want to share some information with us--and again, just share that information with Claudia. We will give people sufficient time, and it will probably be later in the summer that we do that so that we give you plenty of time to think about that. We will also send out an e-mail to our e-mail list, asking those providers or people that are on the list if they would like to share anecdotal information, much like what we might have heard this morning from the residential treatment people, we would be most happy to hear from you also. But we will send that e-mail out. We are finding that, on another topic, when we invite people to send

comments, they have been very gracious to do so. So just so that you know, we are planning ahead and kind of thinking in those lines. Okay. And with that, today we are adjourned, so have a safe trip back to your home. []